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MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, nurses, public officials and students of social problems find it of special value.

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Articles

Book Reviews

JOSEPH HIRSH

Methods and fashions of suicide

Part 2

PART 2: METHODS AND FASHIONS OF SUICIDE

The agents and methods of suicide have received relatively little attention by serious students of this subject. They have been regarded almost as incidental—and at that, mechanical rather than dynamic—factors in the process of self-destruction. Yet it is entirely possible that the method might provide a real clue to the motive and process of suiciding. This certainly appears to be a possibility in those who seem to punish themselves for their act by suiciding in a most painful or mutilating manner. The method of suicide might be selected, on the other hand, to serve the function of punishing someone else. There are, of course, many other possibilities.

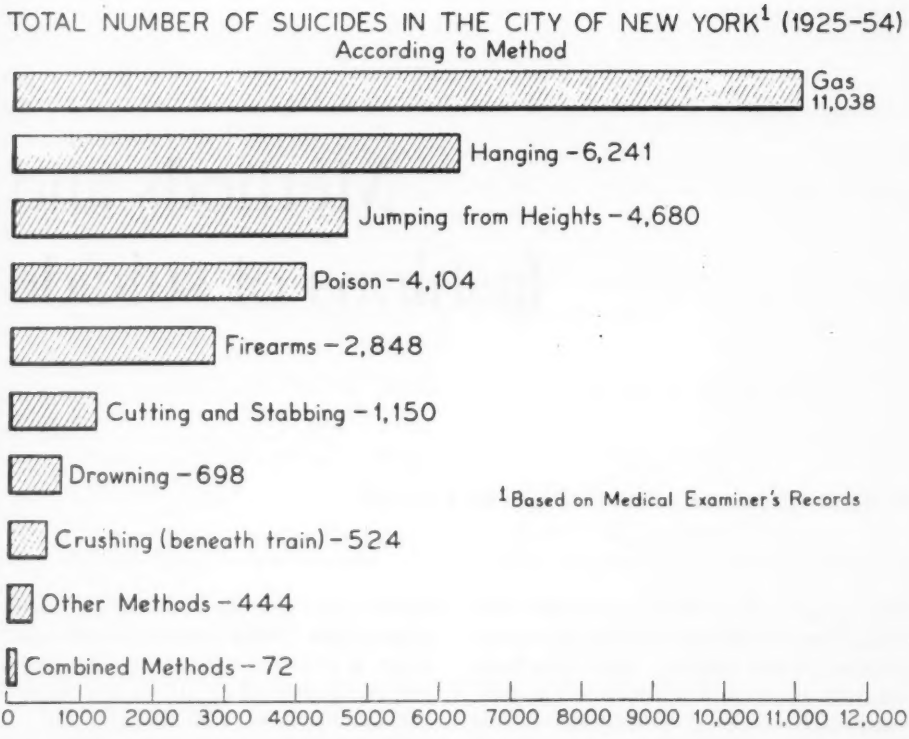
Are the agents and methods of suicides correlatable with age, sex, religious, occupational, racial and social groups? Are there typically masculine or typically feminine methods of self-destruction? Do youngsters kill themselves in certain characteristic ways and their elders in certain other ways? What determines the selection? Is it chance, personality, time, place, culture or just what? Is there a fashion and fashionability to suiciding?

The answers to such questions might offer not only a clue to the dynamics of suicide but would undoubtedly be of practical value in programs of prevention and control.

Actually, what can be said of the agents and methods of suicide? A few broadly stated principles have emerged from observations to date. Though the observation is not supported by the data from the

Dr. Hirsh is associate professor of preventive and environmental medicine at the Albert Einstein College of Medicine, Yeshiva University, New York. Part 1 of his 4-part study of suicide appeared in the October, 1959 issue of *Mental Hygiene;* Parts 3 and 4 will appear in future issues.

CHART 1



City of New York (see Chart 1), it has been noted that many suicidal acts are multiple in method. It's as if the suicide believes that a good thing can be made better by doubling, tripling or quadrupling the dosage or that if one lethal agent can insure death two or three will make you deader. Intelligence, knowledge, professional know-how and levels of sophistication have little or nothing to do with the case.

A physician who knew better triply guaranteed his death by an injection of morphine, ingesting curare and infusing a continuous intravenous drip of sodium pentathol—any of which individually would have been lethal! Ingesting poison and jumping from a window, a bridge or a ship is another common pattern. The epitome of multiple methods of suicide, however, is described by the New York City Medical Examiners group in their classic text on legal medicine (1). Rube Goldberg-like, the would-be suicide inflicted repeated scalp wounds and cut his throat. Apparently bleeding too slowly, he slipped a noose around his neck and hanged himself from an overhead gas pipe which broke. Autopsy revealed that death had ensued from illuminating gas poisoning!

Children and elderly people who suicide often do not view their act as a terminal

TABLE 1

Methods of suiciding in the United States, by age and sex, 1954 [1]

METHOD	NUMBER OF DEATHS					
		10–14 Years			*15–19 Years*	
	Total	*Male*	*Female*	*Total*	*Male*	*Female*
Poisoning	6	4	2	63	30	33
Hanging and strangulation	19	17	2	46	43	3
Firearms and explosives	12	9	3	133	108	25
Other				19	10	9
Total	37	30	7	261	191	70

[1] From *Vital Statistics of the U. S.*, Vol. II, 1954.

one. Rather, they view it as a process—of punishment, of gaining love and affection or of relieving pain. And their methods of suiciding are often similar. As has been pointed out elsewhere, "a good many elderly people—as if living out a second childhood—express in suicide the violence of children who when rejected, unloved or traumatized by loss of loved ones behave violently. Thus they tend to make their death as shocking as possible. They pitch themselves out of windows of tall buildings or jump from bridges or cliffs; they drown; they hang themselves; they throw themselves in front of moving trains or trucks" (2).

Methods of suiciding in children are essentially action methods. There do seem to be, however, masculine and feminine trends in children just as there are in adults (see Table 1). The most frequent tool for both sexes is firearms and explosives; the chief means for boys is hanging and strangulation but for girls is poisoning.

If the elimination of current, regional or topical pain is the immediate goal, this may express itself in the use of a gun to commit suicide. Such suicides shoot themselves in the tables of the forehead and temples, the sites where headache pain is felt most keenly. People who are "all tied up in knots," viscerally speaking, attempt to relieve this immediate pain, as well as the total pain, by opening their chest or abdominal cavities. The impression, which is yet to be supported statistically, is that women in the third, fourth and fifth decades of life who commit suicide often tend to use stabbing weapons. Many of these women, it is discovered, have had menstrual or menopausal difficulties, problems relating to pregnancy, child-bearing or childbirth, unsuccessful marriages or love affairs, or other psychosexual difficulties.

While it is yet to be determined from current studies of a large body of data for the city of New York whether there are characteristically feminine and masculine methods of suicide, the findings from far fewer cases in London, a city of similar size, suggest that there may be sex-typical patterns (see Table 2). Women appear to employ asphyxiation with gas and poisoning—methods of suiciding which involve an important factor—time—or allowing for rescue efforts and resuscitation. Male methods generally do not leave any margin for error, involving, as they often do, patterns of violence.

Actually there has been little change in

TABLE 2

Percentage incidence of suicide method employed by males and females in 355 cases *

	TOTAL	MALE	FEMALE
Carbon monoxide	40.6	40.3	41.0
Poison	20.6	16.7	27.9
Jumping from building	12.1	10.3	15.6
Drowning	8.1	9.0	6.5
Hanging	7.9	10.3	3.3
Cutting (throat, wrists, etc.)	5.0	6.4	2.5
Crushing (beneath train)	3.1	3.9	1.6
Firearms	2.0	2.6	0.8
Setting fire to self	0.3	–	0.8
Electrocution	0.3	0.5	–
	100.0	100.0	100.0

* From *Suicide in London: An Ecological Study* by Peter Sainsbury, New York, Basic Books Inc., 1956.

the fashions of suiciding over the centuries. The basic methods involve the use of cutting and stabbing instruments, guns, crushing as a consequence of leaping from a height or beneath a vehicle, various methods of traumatic asphyxiation and poisons. The statistical breakdown of these methods among some 32,000 suicides in New York City is shown in Chart 1.

The most common site of cutting wounds is the throat. The individual generally holds the weapon in his right hand and starts the incision on the left side, drawing the blade to the right. If left-handed, he may incise the right side of his neck, drawing the blade forward and downward. A characteristic pattern of suicidal wounds of the neck shows repeated "hesitation marks," suggesting a consciousness of pain or fear before the final slash is made.

In cases of ineffective self-inflicted wounds of the throat, slashes may be found on other parts of the body, particularly the wrists. Cutting suicidal wounds of other parts of the body may involve, in addition to the wrists, the inner surface of the thighs and, less frequently in our culture—as distinguished from the Japanese—of the abdomen. There are, however, a number of cases on record of partial or complete self-eviscerations in the United States.

The most frequent site of suicidal stabbings is the chest, over the heart region. Usually the individual grasps the knife in his right hand and directs it upward and to the right into the cardiac region of the left side of the chest. Often this is accomplished with one stroke, in which event the knife is frequently found sticking in the wound. Often there is a pattern of wounds in the chest, indicating a number of jabbings, variable in depth and superficial in character, suggesting hesitation. These are comparable to the so-called "hesitation marks" of cutting suicidal attempts.

One curious characteristic of the stab-

bing suicide, whether he stabs himself once or more times, is the fact that he rarely, if ever, stabs himself through clothing. He will open his outer garments and lift his undergarments before thrusting the suicidal weapon home, as if the clothing might act as protective armor plate.

Another common characteristic of stabbing suicides is that the stabbing effort is frequently only one of several in the final act. The suicide will stab himself and, if he is still ambulant, throw himself from a height or into a body of water, or ingest a toxic substance.

Approximately 115 suicidal shootings take place in New York City each year. These comprise 10% of the annual suicides in the city. Their most common site is the right temporal region if the individual is right-handed, the left temporal region if he is left-handed. The middle of the forehead is another popular site. Occasionally the gun may be placed in the mouth, the nose, the ear, variously on the face or under the chin, pointing upward into the brain case.

Gunshot suicides often are grimly bizarre. Take, for example, the suicide who in the act of shooting himself behaves as if he wishes to protect himself from the projectile. Thus he places his hand between the gun and the site of the imminent head wound. As if through design rather than anatomical ignorance, gunshot suicides rarely, if ever, use the military *coup de grace*, a shot generally in the area of the mastoid process.

Bullet wounds of the chest and abdomen are less common than those of the head. Chest wounds are generally concentrated around the cardiac area, but often require multiple attempts because of imperfect anatomical knowledge. Abdominal wounds are generally inflicted in the epigastric region. Here too multiple wounds are inflicted in order to achieve the desired end.

Multiple wounds may involve a single region—temple, chest or abdomen—or a combination of regions where the attempt has been unsuccessful.

Rifles and shotguns are rarely used as suicidal weapons because of their long axis and the inconvenience of positioning them properly in order to achieve the desired end. In suicidal attempts these weapons are generally placed in the mouth, against the front or side of the head, or against the chest or upper abdomen. A recent 4-year study of 167 shotgun deaths by the Maryland assistant state medical examiner showed that 91 were suicides, 57 homicides and 17 accidental. Apparently shotgun fatalities are far more purposive than newspaper reports suggest.

In suicides there are two basic forms of strangulation—by hanging and by ligature (garroting); the latter is far the less frequent form. In hanging, strangulation is achieved by the application of a noose, strap, band or other external mechanism around the neck which is tightened by the weight of the body, thus closing the air passages. Contrary to popular opinion, except in cases of legal hanging death rarely ensues as a result of a broken neck. What generally happens is a simple, mechanical realignment of certain anatomical features of the neck resulting in occlusion of the lumen of the upper portion of the larynx. But there are other factors, notably simultaneous interference with cerebral circulation, thus resulting in almost immediate loss of consciousness and shock once hanging starts. As a consequence, the suicide-to-be, if he has a change of heart, rarely can reverse the process.

There is no one method of hanging. The various methods are based on the simple principle of effecting sufficient traction by the exertion of body weight to

close the airway. This can be achieved in a standing, sitting, kneeling or even in a prone or supine position.

Ligature or garroting is a method of strangulation by which the constricting band is tightened other than by body weight. Most of such strangulations are homicidal; occasionally, however, they are suicidal. The victim actually strangles himself!

Suffocation is that form of traumatic asphyxiation resulting from an obstruction of the airways. This may be achieved by smothering and choking. Smothering occurs when external openings of the airways—the nose and mouth or the laryngeal opening—are occluded by a solid object or finely-divided material. Most fatal smotherings are accidental but occasionally some are suicidal. Among the bizarre suicidal methods used are tying a pillow over the face, strapping broad adhesive tape over the nose and mouth and cramming a bath towel down the mouth. Each of these methods described by Gonzales, Vance, Helpern and Umberger (1) appear to be sex-specific, involving women. Apparently smothering is not a male suicide's method of choice.

Drowning is a form of suffocation occurring when the victim's air passages are blocked by water or other fluid. The cause of death in 90% of drownings is asphyxia resulting from the inhalation of water into the lungs and exclusion of air. A small percentage of deaths occur during submersion as a result of circulatory collapse or syncope.

Drowning is neither a simple, easy or rapid way of doing away with one's self. The process varies, may be extremely unpleasant and may take from 3 to 10 minutes to complete.

One psychologic characteristic more typical of drowning suicides than many other suicides is the fact that they tend to leave so-called suicide notes. During drowning, suicides display a variety of patterns. Some die of shock, almost immediately. These are the syncope victims. The asphyxial types generally go through these stages: inhalation of water at the moment of submersion, panic, reflex spasm of larynx, gulping of water and air, severe coughing and expiratory efforts, more water is inhaled and swallowed, vomiting takes place, respiratory movements become violent, face becomes cyanotic, bladder and rectum empty. Unconsciousness and asphyxia ensue. After respiration ceases the heart may continue to beat for a short time.

Suicidal drownings in New York City average 30 a year or 3% of the total number of annual suicides. Oddly, some of these suicides tie their legs together but leave the arms free, as if to make ultimate escape possible if there's a change of heart, take poison orally or inflict stabbing or cutting wounds beforehand, or jump from a height—a bridge, for example—into the water.

The exhaust fumes from internal combustion engines contain on the average 7% of carbon monoxide, a highly toxic gas. Accidental deaths frequently ensue from running an automobile engine in a confined or closed space, and even occasionally while the car is moving with the windows closed.

Suicidal deaths from carbon monoxide poison are more common than one would suspect (see Table 2). In the past when gas illumination and gas cooking were features of our culture, suicide from gas fixtures as well as carbon monoxide poisoning accounted for the largest number of self-inflicted deaths in studies reported on to date (see Chart 1). "To take the pipe," meaning the gas pipe, was an idiom of that era. It followed a pattern: suicide note,

stuffing window and door cracks, detaching the gas tube leading to a fixture and placing it in the mouth or near the nose, holding the head over the stove's gas jets or placing it in the oven. An occasional by-product of such an enterprise was an explosion which resulted in the suicide's neighbors or family involuntarily joining him.

Suicidal burns and electrocutions are rare (see Table 1). But as an occasional expression of extreme psychopathy an individual will douse himself with kerosene or some other combustible and ignite himself. As an added fillip, aflame he may throw himself from a height. Rarely he will rig an elaborate electrical apparatus to do himself in but such bizarre techniques are employed generally by psychotics with special skills or professional training.

There is an ancient history attached to the ingestion of poisons for the purpose of committing suicide. Among the most classic of the early historical references involves the ingestion of hemlock by Socrates.

A wide variety of substances are ingested. Many are determined by culture, social status, profession, education and economics. Poor and uneducated people tend to use substances that are inexpensive, readily available and accessible, such as cleaning fluids, insecticides and rodenticides. Educated, sophisticated and better educated people generally turn to the barbiturates.

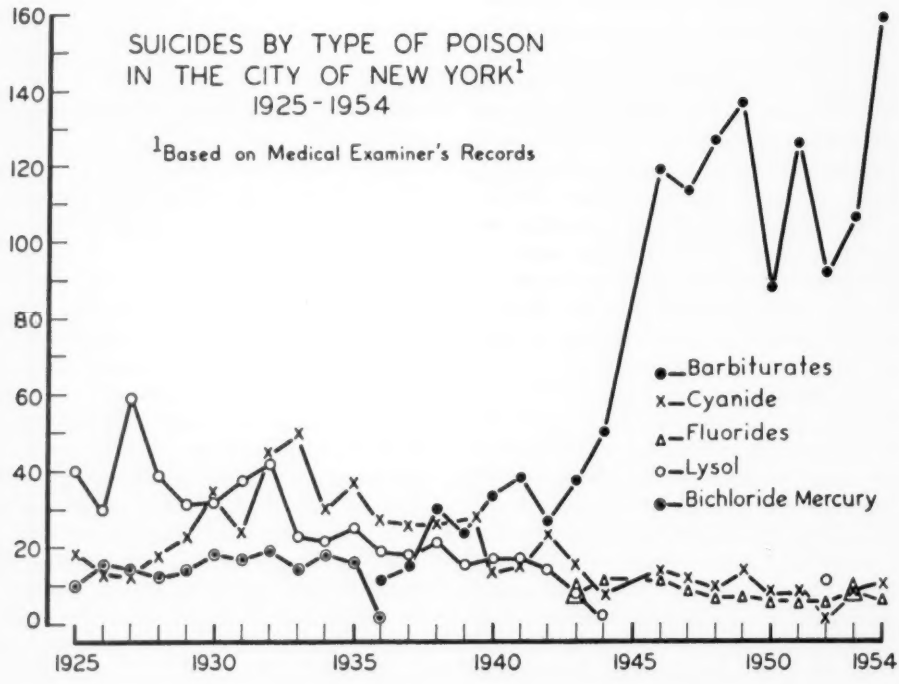
An example of status or professional determination of the means of suicide is that most commonly found among physicians. They tend to use lethal drugs by ingestion or injection. Occasionally, however, as if to deny their special knowledge or to punish themselves for the act they are about to commit, they will use some of the cruder more painful poisons, or destroy themselves by most primitive means.

The patterns of poisoning have been changing in recent years (see Chart 2). The data for New York City reveal the disappearance of bichloride of mercury from the scene by 1936 and of the cresol family such as lysol by 1944. Cyanides and fluorides had a greater fashionability as suicide poisons prior to World War II. They have played a diminishing role ever since. The most dramatic change in suicide poisons is reflected in the widespread use of barbiturates since 1935.

With the advent of the tranquilizers it may be expected that the fashionability of the barbituates too will have passed. The fabulous story of the tranquilizers is actually less than ten years old, dating back to 1949 when Dr. Robert W. Wilkins, came upon a British medical paper on the use of *rauwolfia* in the treatment hypertension. Within a matter of three years *rauwolfia* and its most important chemical constituent *reserpine* became medical household words in the United States. In 1953 along came the second of the tranquilizers, *chlorpromazine*. This drug, which shortly found wide application in the treatment of mentally disturbed patients, triggered the development of scores of other drugs. By 1956 it was estimated that 1 out of every 7 persons in the U. S. took some form of tranquilizer. By 1957 the Medimetric Institute, a drug market research organization, estimated that 36,000,000 prescriptions for tranquilizing drugs had been filled by druggists the preceding year, and that Americans swallowed 1,250,000,000 tranquilizing pills—the equivalent of 300 tons.

The extreme fashionability of tranquilizers is attested not only by their widespread and ready acceptance by the public and medical profession, by the number of jokes and gags built up around them, by the happy economic reports of the pharmaceutical houses, but also—and somewhat on the grim side—by their increasing popu-

CHART 2



larity as a suicide drug. Just as the barbiturates superseded bichloride of mercury so it is safe to conjecture that the tranquilizers may one day soon replace the barbiturates as an important agent of choice in suicide. Increasingly the literature these days warns of the toxic effects of the tranquilizers, the danger of overdosing, the tragedy of true accidents, and the challenge of purposive accidents in which the drugs are playing a chillingly serious role (3, 4, 5, 6, 7, 8, 9).

No less ironical is the grim use to which another product of our age is being put. Like so many other plastic articles, plastic bags were designed to make life a little easier and pleasanter. But by the spring of 1959 health officials, merchants and manufacturers were warning parents—who under any circumstances should be alert to the potential hazards implicit in the most innocuous of products once in the hands of children—of the dangers of plastic bags. The warning unfortunately grew out of a disconcertingly large number of accidental deaths due to suffocation in which plastic bags were the agents. Reports of these deaths had hardly been published when they were joined by other, even grimmer reports. They had become, if not a fashionable agent of suicide, sufficiently popular to add to the list of reasons for curtailing their use.

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PAUL HAUN, M.D.

The empty ranks

The preliminary findings of the task force on man power of the Joint Commission on Mental Health and Illness lend a note of authority to the impressions many of us have gathered in recent years. Our community services, our clinics and our hospitals suffer from a shortage of trained professionals due less to local recruitment difficulties than to an absolute shortage of personnel. The situation is complex, and we are indebted to the task force for clarifying many of the unpleasant realities. Broad social factors have affected our economy as a whole. The low birth rate prevailing during the depression years resulted in fewer students entering college during the late 1940's and early 1950's. With fewer candidates from which to choose, graduate schools have found it difficult to maintain their enrollment, and many have had to reduce their admission requirements.

Enticing opportunities for well-paid employment making little demand on the knowledge or skill of the applicant have siphoned off a great many young men and women who in less prosperous times would have continued their education and in some instances, at least, have entered the mental health professions.

Attempts to capture the interest of the shrinking group of college graduates have been intensified. We have all heard of the blandishments to which the able student is subjected by representatives of business and the professions; of the subtle and not so subtle court paid to professors and heads of departments urging them to steer their promising students into one or another field eagerly promoted by the lobbyist.

To maintain our present teacher-pupil

Dr. Haun, who is director of psychiatric education for the New Jersey Department of Institutions and Agencies, presented this paper June 5, 1959 at the 8th annual meeting of the New Jersey Association for Mental Health.

ratios in primary and secondary schools, one-half of all college graduates for the next ten years would have to become teachers. The educational prospect for our young people is further darkened by the flight of qualified instructors, particularly in mathematics and the physical sciences, into better paid and often less demanding jobs in industry. How successfully our educational system will meet these problems, how well prepared it is to absorb the deluge of war babies now well along in their teens, remain to be seen.

The National Man Power Council offers four indices for recognizing man power shortages: (1) the existence of a demonstrated social need; (2) the appearance of budgeted job vacancies; (3) a rise in salaries; and (4) the presence in jobs of inadequately trained people. In spite of the lag in salaries characteristic of public agencies I think we can agree that every mental health profession meets these criteria.

Approximately 350 trained psychiatrists become available each year to meet the needs of the entire country. Since the majority enter private practice, it is estimated that fewer than 100 individuals enter public institutions and clinics.

For some time social work jobs have been multiplying with such rapidity that the spread between supply and demand has increased rather than narrowed. The prospects for psychology are much the same.

The situation in nursing is a little brighter because the number of nurses being trained is increasing at a more rapid rate than would be expected from the growth in population alone. There is some reason for believing that we can attract a proportionately larger number of these graduates into the field of psychiatric nursing.

Present shortages exist, however, and in all likelihood will continue in other mental health fields, such as occupational therapy, hospital recreation, counseling and group work.

Dr. Albee, director of the task force on man power, puts it this way: "The blunt facts are simple. We do not have enough trained personnel to handle the demands of our society in the field of mental health, and these demands are growing faster than we are training personnel to meet them."

The studies of his group call attention to the well-recognized fact that mental health personnel tend to gravitate to urban centers, rather than to distribute themselves in accordance with the geographic need. There is also evidence that graduates are disposed to settle in the same general area in which they were trained. The presence of educational and training centers are, accordingly, related to the number of personnel available.

How have we met these problems? What have we done to attract new recruits?

We have followed the lead of industry in a progressive reduction of working hours until today the 40-hour, 5-day week is as much the standard in a mental hospital as in a General Motors plant.

We have patterned our personnel practices after those adopted by Standard Oil, DuPont and other large business enterprises: paid vacations, cumulative sick leave, efficiency ratings, merit promotions, grievance procedures, job security and free insurance.

We have taken a leaf from Madison Avenue and—under the somewhat misleading name of public education—have conducted our advertising campaigns and launched our propaganda barrages. We buy television and radio time or have it given to us; we try to make our pamphlets on service careers as eye-catching and persuasive as possible; we ring an annual bell for mental health.

Recently we have moved into the fields of education and research, where we conduct training programs, issue diplomas, grant scholarships, award stipends and submit protocols in much the same fashion as does any state university or private college.

Lastly, we have adopted, in their entirety, mercantilistic criteria for the establishment of salaries. These impose two essential guidelines. First, we must keep a wary eye on the general economy. What is the going rate for all employment categories at General Dynamics, A. T. & T. and Montgomery Ward? Second, we must meet and, if possible, surpass the scale paid by our competitors in neighboring states.

The pressing question remains whether further shortening of the work week, longer vacations, increased retirement benefits, stepped-up advertising, fatter stipends, more scholarships and still higher salaries will put us on Easy Street. Do we need to do more of what we are already doing? Do we need to do it better? Do we need to do something entirely different?

George Devereux,[1] the sociologist and anthropologist, has recently called attention to the pervasive influence of cultural thought models on the pattern of human life. At each stage in the development of civilization, in the simplest to the most complex society, there are certain ways of thinking, certain value systems and certain fashions of looking at the world and at man which exert an impressive influence on all human institutions and on every living person. A troublesome quality of these interpenetrating models is the profound difficulty we experience in identifying them in our own civilization and the relative ease with which we can see them in operation in past historical eras and among contemporary peoples whose social organization is radically different from our own.

Perhaps the readiest analogy to our singular position in these matters is to be found in the realm of fashion. In 1929 we walked our streets, worked, traveled, attended meetings and mixed with our fellows in much the same way and with much the same purposes as we do today. Everyone looked natural to us. We looked natural to everyone else. Even those individuals who strove to be fashionable, to be considered the best dressed woman or the best tailored man of the year were in our eyes only more exquisitely gowned or better groomed than the rest. Thirty years later we see the same clothes, the same manner of walking, the same hats, the same use of cosmetics as grotesque or amusing, appropriate for nothing but a masquerade. Will our contemporary fashions appear less odd to us thirty years hence?

The cultural thought models with which we are concerned are at the same time more significant than the whims of fashion and less easy to identify. As with fashions, however, they can be seen most clearly in historical perspective. For example, it is comparatively easy for us to trace the effects of religious faith in Europe during the Middle Ages, to see the great cathedrals as a logical result of belief in a Christian God, the crusades as understandable corollaries, and scholasticism with its absolute reliance on authority as a necessary consequence of ecclesiastical absolutism. It is easy for us to see the rationality of the 18th and 19th centuries as a necessary outcome of the enlightenment; to understand the Utopians' dream of translating into human affairs those principles of observation, logic and experiment which were so astonishingly successful in the physical sciences; to grasp

[1] "Cultural Thought Models in Primitive Theories," *Psychiatry*, 21:4 (November, 1958), 359–374.

the depth of the new faith in the inevitability of progress.

Are there thought models implicit in our contemporary culture of which we are partially or totally unaware? Do these find diverse expression in our value systems, in our rather vague picture of the future, in our somewhat misty ideals and quite concretely in the automatic attitudes we adopt in approaching familiar problems in the field of mental health? I suggest that we have been influenced by one such thought model—the idea of production for profit.

Too much of our material abundance has resulted from this cultural pattern to give us ground for believing that we have entirely escaped its influence. Objectively, the modern world *is* the direct result of a conviction that by blending in their proper proportions capital investment, machines and technical skill, monetary profits can be earned by making it possible for everyone to own a refrigerator. Profits are the necessary incentive in this transaction since they permit all participants to purchase those material objects that they prize. The validity of this view cannot be challenged. It has worked and its success has surpassed the most optimistic prophesies.

The question, I think, is whether the cultural thought model of production for profit applies to mental health. What desirable product do our hospitals manufacture? Is the primary orientation of our clinic workers necessarily toward profit? Are incentives for the General Electric shop foreman identical with those for a head nurse?

I would in no way disparage the form taken by our conventional efforts at recruitment. I raise no questions as to their relevance and no doubts as to the necessity of our continuing along comparable lines. What I do suggest is that by limiting our efforts to what are essentially mercantilistic parameters, by accenting only those personal rewards which are *all* that business has to offer, we have neglected (and even at times have forgotten) the lasting attraction of those very things which set us apart from factories, from brokerage houses and from construction companies.

David Riesman [2] predicts a shaky future for the profit incentive as the prime human motivator in post-industrial civilization. "Even the most confident economists," he writes, "cannot adequately picture a society which could readily stow away the goods likely to descend upon us in the next fifteen years . . . with any really sizable drop in defense expenditures. People who are forced by the recession or by fear of their neighbors' envy or by their own misgivings to postpone for a year the purchase of a new car may discover that a new car every three years instead of two is quite satisfactory. And once they have two cars, a swimming pool and a boat, and summer and winter vacations, what then?

"In better educated strata the absence of goals for leisure and consumption is beginning, or so I would contend, to make itself felt. In these latter groups it is no longer easy to regard progress simply in terms of 'more'; more money, more free time, more things. There is a search for something more real as the basis for life . . . Such Americans are not satisfied simply to attain material comfort far beyond what their parents possessed . . . In fact, the younger generation of reasonably well-off and well-educated Americans do not seem to me drivingly or basically materialistic; they have little ferocious desire for things for their own sake."

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[2] "Leisure and Work in Post-Industrial Society," in *Mass Leisure*, edited by Eric Larrabee and R. B. Meyersohn (Glencoe, Ill., Free Press, 1958).

Medicine has been from immemorial time one of the three learned professions. The essential and lasting distinction from occupations that are commercial, agricultural or mechanical is that physicians, by training and by personal dedication, are members of a *professional* group. Let me call your attention to the significance of this word. It derives from the Latin *profiteri,* which means to profess, and to profess means to be bound by a vow which is freely taken and openly declared. It means that a faith is asserted and a calling chosen to which one dedicates his life. A profession asks nothing of society but an opportunity to perform its essential function in dignity and in honor. It demands proficiency of its members and imposes its own discipline upon them. Since it is understood that every member will attempt to surpass himself, it awards prestige sparingly to those whose self-imposed standards are the highest. It is the collective conscience of excellence. It does not know and scorns to learn the techniques of bargaining. Its goal has never been production for personal profit, nor can this aim ever become its motivating force. It is the last refuge for those who would dictate only to themselves, whose self-respect demands a purpose which can not be reduced to absurdity, who believe in the ultimate worth of the human spirit.

As a member of the profession of medicine, the physician recognizes one opponent only, one enemy against whom all his battles are fought, all his resources marshalled. That enemy is disease. In this kind of warfare he is obliged at times to match wits with his patient, to deny him what he wants, to rout his fears, to condemn his prejudices, to uproot his settled habits and to chivy him into actions which would never otherwise be taken. It is the physician's duty to fight—with the patient's cooperation or if necessary without it—against his illness. This is scarcely the kind of intervention any of us would seek without overriding cause. It remains a service without which all of us would be the poorer.

The hospital nurse, the occupational therapist, the recreation worker, the psychologist or the social worker who qualifies for membership in one of the supportive medical professions all share in the immunities and privileges as well as in the obligations and responsibilities that professional status imposes on the physician.

Society has always accorded a highly specialized place to the professional. It goes farther in granting distinctive exemptions and imposing unique obligations on the professional in medicine. There is a clear but unspoken recognition of the nature of this social contract. The doctor is not expected to have either immortality or the certain cure of all disease within his gift. He is expected to be selflessly concerned with all his patients. With this expectation goes the tacit understanding that his medical involvement in the welfare of others leaves him neither the interest nor the energy to advance his own material or social position by the devices open to other men. Society willingly takes over responsibility for such matters.

The persistent viability of these implicit understandings is indicated by the incredulous shock we experienced a few years ago when a tiny group of misguided doctors went on strike against intolerable conditions in a certain state hospital; by our mocking doubts of the professional integrity of the rare physician who becomes independently wealthy through the practice of medicine; by our inability to conceive of a community which would allow "its doctor" to starve.

It is both easy and fashionable to be cynical about these traditions and to point to the venality of individual physicians, just as it has always been easy to single out corrupt politicians, traitorous military leaders and renegade clergymen. The professionals of medicine have no monopoly either on virtue or on vice. Their failure on occasion to measure up to the standards we hold for them is sorry evidence that our expectations are at fault. The frequency with which many surpass in dedication all that we might dream of asking is sufficient basis for the honor we continue to pay their ideals.

It is easy and fashionable to satirize such old-fashioned words as respect and unselfishness, dignity and faith, honor and devotion. We are instructed that every man has his price; that principles are always soluble in gold; that the rungs of the ladder of success are formed by the necks of our competitors. These sour views have currency among those whose emotional wounds are slow to heal, whose need for approval, for acceptance and for love is great. No further exposition of their essential inaccuracy is required than the knowledge that no sane man honestly believes that such principles guide his own conduct.

Our finest minds are sick of cynicism. The best of our youth is eager for a cause to live for, not a frightened conformity to die within. Each has a vital need to shape the future, to make his personal imprint on the face of time, to wrest a fragment of order from the vast disorder. Not a few are shocked at the educational pressures which in the words of John Unterecker would machine them into well-rounded intellectual billiard balls, compartmentalized, isolated, depersonalized.

It is to this elect that we can and must appeal. It is to those who have seen the feet of Moloch that you and I can and must address ourselves. It is by our convictions and our beliefs, by our spoken thoughts and unspoken attitudes, by our value judgments and our very flippancies that we can remind the eager child, the curious stripling and the impatient youth of an ethical order which puts selfless devotion to mankind above most human endeavors, which respects true dedication and deeply honors those who would serve. Judith Crist has added the matter up with admirable brevity. She puts the inducement quite simply as a "sense of service beyond one's self and a consciousness of craft; in short, professional pride." This is the gauntlet I would throw down before our empty ranks.

SIDNEY WASSERMAN

Casework treatment of a homosexual acting-out adolescent in a treatment center

In this paper I should like to focus on an adolescent whose primary symptom was homosexual acting-out behavior. The main attempt will be toward demonstrating that casework techniques can be applied in such cases, with encouraging results. In addition, the treatment of this adolescent is within the milieu and controlled setting of a residential treatment center.

Because of the severity and deep-rootedness of the problem, the treatment should be done only under close casework supervision and psychiatric consultation. Conferences between the caseworker, casework supervisor and psychiatrist were held to determine the applicability of casework to this boy.

Because of our limited knowledge in the treatment of sexual deviations such as overt homosexual behavior, we caseworkers approach individuals of this symptomatology with understandable reluctance and hesitancy. Certainly the significance and handling of such a symptom in an adult may differ considerably from that of an adolescent. This is specifically so because such behavior in adolescents is frequently part of the normal adolescent conflict.

We know that with the onset of puberty the adolescent is torn asunder. At this stage of life there is an upsurge of libidinal energy which breaks down the rapport that had temporarily resulted between the ego

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and id (during latency). Impulses (aggressive and sexual), which during latency were brought under balance, at adolescence create an onslaught which overwhelms the ego and supergo. The adolescent suddenly indulges in activities which heretofore had been considered taboo and he (or she) begins to resist and rebel against all forms of authority.[1]

The adolescent whose behavior is manifested by the symptom of homosexual acting-out presents a unique problem. It is at this period of life that the adolescent is seeking identifications. Frequently the young person forms an attachment to another of his or her own sex and age which takes on the form of passionate friendship and love. Because of the pressing conflict of instincts, the attachment may be expressed by overt homosexual behavior. It is therefore difficult to determine at what point the adolescent is forming a homosexual, pathological adjustment which may become a fixed pattern and perhaps be irreversible, and what is merely the "temporary" acting-out which will gradually be replaced by stronger inner controls and defenses.

In working with this particular adolescent boy, it became extremely important that the psychiatric recommendations and suggestions be such that they could be implemented by casework technique and the environment. Because the homosexual problem in this case had become a conscious matter to the youngster, the casework treatment needed to be geared to reality and ego support. The amount of ego needed to be determined as well as the degree of reality assessment and inner anxiety. Sublimating outlets for the aggressive and sexual impulses and activities that would be supportive and stimulating to the ego had to be provided by the environment.

This is the case of A, a tall, sandy-haired, green-eyed, sharp-featured, bright, handsome young man of 19 with a well-built body of almost classic proportions. He was placed at the treatment center when he had just turned 14 years old. At the time, he appeared older than his age owing to his almost mature-looking build, his outward poise and politeness and his well-dressed appearance.

He is the eldest of three boys and one girl, his brothers being four and a half and six years younger, his sister seven years younger. He comes from a mixed marriage; his father is Jewish, his mother Gentile.

Since the age of five (according to the parents) A presented problems. He lied and stole, and was uncooperative in any routines such as eating, washing, family rules, etc. For periods of time he was enuretic. In general, he was very immature, even infantile, and tended to isolate himself from both peers and adults. Occasionally he was extremely provocative to younger boys and sought out opportunities to beat them up. In spite of superior intelligence, he did poorly in school, failing in several subjects and receiving gratuitous D's in others.

A severe and hostile atmosphere existed between A and his mother, who was controlling, aggressive, ambitious and competitive with him. She had a strong need to mold him into a submissive, polite boy. The marital situation was a poor one in that the husband was most passive and reluctant to assume a more assertive role as husband and father. He worked in a factory and was consistently reminded by his wife of his inadequacy as a successful breadwinner. In all, the role of disciplin-

[1] Anna Freud, *The Ego and Mechanisms of Defense*, 158–70.

ing the children was left to the mother, which was undoubtedly overwhelming and frustrating for her. A had particular difficulty with his next younger brother C, whom he described as always being favored by his parents, particularly his mother. A seemed almost indifferent to his other siblings.

As his behavior progressively deteriorated, it became of extreme necessity to remove him from the rejecting, tense environment of the home. On his arrival at the treatment center he made a most promising, appealing, initial impression, but underneath the clean-cut, wholesome look was a deeply angry, damaged, frightened, sensitive, unloved child who had, in a large sense, given up on himself.

In brief form this, then, is the history of A and some of the presenting problems. It did not take long to observe that the pleasant, seeming outgoingness of this boy was superficial—and he didn't allow relationships to develop beyond the superficial. During the first six months of casework interviews, A handled all reality discussion by flights into fantasy. He insisted on talking about jet guns, model rockets and "super bathyspheres." He denied any reason for being at the treatment center except difficulty in school and escaped all discussions as to feelings around placement and separation from home.

During this period, it was decided through supervision, psychiatric consultation and a staff planning conference that the caseworker should hold up reality whenever possible. It was felt important that in order to reach this boy the caseworker should talk at some length with him about rockets, jet guns, etc., and of his plans to construct such projects. The psychiatric thinking, at the time, was that such inventions might be a projection of himself and the telling of these inventions to his caseworker might be his way of wanting the worker to be his friend. Talking to A about rockets and guns was seen as a means of establishing a relationship with A and of breaking through his defense of being totally self-relient, independent and self-sustaining. By so doing, we hoped that A's feelings would them come to the fore and the desire for a relationship would take hold.

At the end of the first six months there was the first discovered incident of A's engaging in homosexual play with one of the younger boys of another cottage. This was then followed by A's first admission that he "hated" the center. His homosexual acting-out with younger boys increased. When confronted with this by cottage personnel and the caseworker, he was vigorous and hostile in his denial. With the emergence of this acting-out came increased overt hostility along with frequent withdrawal and isolation. However, there was a decrease of fantasying, especially with the adults in the cottage, and as he gave up the fantasying, the overt homosexual behavior continued. Throughout the first year of casework contacts, A's defenses seemed to be primarily projection and denial manifested by flights into fantasy. He was also suspicious, and frequently accused others of spying on him.

Throughout that fall he developed a strong, homosexual attachment to a 12-year-old boy. A freely admitted that he "loved" the boy very much, "more than he ever loved" his parents or brother. At this time it became necessary to set up extra controls and supervision for A to protect him as well as the other boys. He was not allowed in the younger boys' cottages (unless accompanied by an adult) and he could not invite them up to his room. The group contagion of the prob-

lem, because of the normal existence near the surface of such feelings in adolescents, can present considerable difficulties in maintaining outer controls and limiting the acting-out whenever possible.

The previous summer, I had worked as a counselor with A in his cottage. By the end of the summer he had told me of his homosexual feeling toward the 12-year-old boy to whom he had such a strong attachment. In the fall when I returned to the center as a caseworker (A's worker was leaving) A was assigned to me.

In his first interviews with me he referred back to the previous summer when he admitted his homosexual problem to me. I accepted what he said but did little or no exploring except to underline that this was a problem and that he seemed worried. Over a series of interviews he admitted his concern more and more and began to bring out that he feared he could not control his acting-out. This admission came after I took a definite stand to the effect that having and talking out these feelings was all right but that acting them out was unacceptable. This became the theme of our contacts for about six months.

During this period, on the basis of the presenting material the psychiatrist pointed out that A could be treated only if he felt more anxiety. This caution was based on the fact that A was acting-out and showing little concern about his behavior. The acting-out interferred with treatment and it would have to be brought under control before he could be reached. The lack of anxiety, it was stressed, made treatment of such overt behavior unpromising. However, it was decided that I continue to try to stir up his anxiety by pointing up his behavior as unacceptable and by telling him that he was expected to learn to control it. The need to hold up reality to him and to support his weak ego whenever possible was stressed by the psychiatrist.

With the implementation of these suggestions and direction, A became noticeably anxious. He began to hide his face, when talking to me, shielding his eyes with his fingers and looking down at his feet. He spoke of how "ashamed" he was and said he would "rather be dead" than talk of his homosexual feelings. I had to assure him that talking was right. When he spoke of his fear that he would not be able to control his feelings, I was reassuring but firm. I let him know these feelings were rough on him but said he was expected to learn to control them; this was what society and the center expected of him. Furthermore, I told him he didn't help himself by acting-out as he involved another person, and this was serious. I underscored my concern for him. His behavior could only bring trouble and hurt and unhappiness. He had been hurt and unhappy enough.

With this kind of empathizing, A slowly started to bring out his negative feelings toward his parents, particularly his mother. He felt his parents did things wrong and said he couldn't stand it when his mother yelled and screamed at him. He recalled the constant arguments in the home and said he was always fighting with his mother, sometimes with his father, and practically all the time with his brother. He brought out that his parents had often sent him away. He recalled that when his brother C was born he was sent to an institution for six weeks. He was mistreated there and, according to him, his parents didn't seem concerned. He felt he had been tricked into coming to our center. He had thought he was coming to a "glamorous" setup and had not been told that this was an institution for emotionally disturbed children. He hated his parents for sending him here. It seemed to him that the

only children who came here were those who were "useless and whom nobody wanted." He wondered if "this is really life?"

By that winter A began being extremely hostile to me. One day after I had watched a basketball game at the center's gym, in which A participated, he came for his appointment and blasted me. I was "spying" on him. He didn't want me ever to come to the gym again. When he calmed down he was able to admit that seeing me outside the office was upsetting to him. In the next moment he exploded and insisted that I was "not curing" him. The only reason he was coming for his interviews was to let me know how much he hated me.

Concurrent with these expressions of intense hostility toward me, there were rather dramatic changes in the cottage. A became an active participant in group activities and was thoroughly enjoying the participation. He began to stay with the group and to take on a leadership role. The boys showed a real respect for what he had to say and offer, and his ideas started to be "picked up." He appeared to be more genuine and friendly. Most of all, there were fewer and fewer incidents of overt homosexual behavior. Though his sexual behavior was better controlled, he was most stimulated in the evenings when the boys took showers. He would wait until all showers were taken and then he would sneak into the bathroom. If sexually aroused when accidentally seeing a boy in the nude, he would start to yell, have a temper tantrum, and then bring himself under control.

In his casework interviews, his hostility, after about six months, began to lessen. He spoke of feeling better and talked about being in a "neutral zone," of not feeling sexually attracted to either boys or girls. For the first time he recognized that he was being helped, and the tone of his conversations began to change from "I can't be helped" to "I have been helped." At one point he said: "When I came here, I knew right from wrong but it made no difference to me, for I had no past and I didn't feel I had a future. Now I can look at my past a little bit and I feel I have a future. I was like a little boy in a big world and I felt very lost."

After two and a half years of failures and marginal work in school, A completed junior high school with D's and some C's. His greatest difficulties were in concentrating, in his short attention span and in continually daydreaming. However, the first signs of a freer, spontaneous manner appeared and there were the beginnings of achievement.

Late the following summer A was seen by the psychiatrist (in order to verify casework impressions). It was felt that he was showing better control of his sexual problems. He refused to discuss his sexual problems with the psychiatrist, which was indicative of having built up some defenses around this. He related on reality subjects, which suggested increased ego strength. The psychiatrist felt I should allow A to talk about his homosexual problem as much as he wanted.

Around that period, A was also re-tested by the psychologist. Two and a half years before his tests revealed a picture of a boy functioning intellectually in the bright normal range (full scale IQ 114). Now his intellectual level was in the superior range (full scale IQ 121). Two and a half years before he resisted any forms of self-expression by maintaining a rigid guard and refusing to expose himself. Now he was still somewhat restricted but he showed a remarkable change in the freedom and spontaneity of expression within the bounds

he had set up. He showed a neurotic type of adjustment but more social awareness.

For the next six months however, A seldom spoke of his homosexual feelings except to say that from time to time he got aroused and anxious. But he was able to keep these feelings under control. With the internalization of his anxieties and the controlling of his acting-out, he showed more concern about his physical health. Through most of his interviews, he kept telling me that his heart was beating too fast and that he feared it would stop or that "a bubble or something like it" was trying to pass through his heart.

As he spoke of his life, he said: "What can I do? I can't live with my parents. I have no future, my life is ruined, there is no one to love and if I can't love my parents, there's no one." I acknowledged his concern around this and also pointed out how far he had come, particularly in showing better control of his behavior.

With the lessening of verbalization of his homosexual feelings and the revealing of increased inner controls, the diagnostic picture changed. It had been about a year and a half since the psychiatrist had indicated that A could be treated only if his anxiety became apparent and that this could occur if his acting-out could be brought under control. Now homosexuality was seen as a neurotic symptom; the boy would require intensive treatment. The psychiatrist suggested that I point out to A that he could talk to me about his sexual problems but that he might someday need more intensive help from a psychiatrist. He felt it important that I point out to A those goals and areas in which I could be of help to him. A's signs of increasing ego strengths, according to the psychiatrist, made the prognosis more favorable.

At the same time, in supervisory conferences, it was felt important that I help A to see his parents more realistically, to see that they were confused and unhappy. I might point out that as a child he couldn't help reacting the way he did—with anger. It was important, however, that he realize he had his own life, that though he couldn't change the past he had a responsibility to himself about the future. We needed to help him develop a concept of self and to recognize himself as separate from his parents. The symbiotic and seductive relationship with his mother could be countered by helping him to see his separateness and to see that what he wanted and did with his life rested with him.

In the months that followed I began to initiate and implement the plan that evolved in the shared thinking of the psychiatrist, supervisor, staff conferences and myself. By the following winter A was letting me know that I wasn't "giving him enough." He kept expressing the wish that I were a psychiatrist, and spent much of his appointment time wanting to know why I didn't become a psychiatrist. He informed me that he was still occasionally bothered with his feelings toward boys but said he could control them, adding that sometimes he didn't even have to think about controlling them—"it just comes natural."

Around that time he showed a strong interest in hypnotism and insisted he was going to hypnotize other boys on campus. I was definite in stating that hypnotizing other boys was very serious and was prohibited. A exploded, demanding that I allow him to hypnotize others. He insisted that I never allowed him to do anything. A few days later I was visiting in the cottage when A called down from his room and asked me to come up. When I arrived I found him in the process of hypnotizing one of the boys. I asked the boy

to leave. After the boy left A raged at me. When he calmed down I pointed out that he was not a physician, that he had done something illegal and dangerous, and that I did not want any harm or hurt to come to him.

In a pathetic, grateful manner, he answered: "When I lived at home my parents never allowed me to grow up or do anything for myself. Sometimes I did things behind their backs and then I felt bad inside. Because you mean so much to me and I don't want to feel bad I won't hypnotize others."

Somehow I felt this incident may have paralleled in A's mind the time his mother walked in on him and his brother C when they were involved in homosexual play. A couple of weeks earlier A had recalled this episode in an interview with me. He remembered how hysterical his mother had become and how she had screamed at him about his "naughtiness and filth." Furthermore, she had protected A's brother and had blamed A entirely for luring his brother into it. This was devastating to A.

Early the following spring A began talking to me of his feelings toward girls. He said he was no longer so shy, and found it easier to talk to girls. He began to hang around the girls' cottage and started to learn to dance. Several girls showed a pronounced willingness to get closer to A, but their eagerness frequently made him withdraw from them. He talked then of being more interested "in photography than in girls."

His hostility toward his parents lessened. He was seeing that although his parents were no different, he could get along better with them during his periodic visits home. One day he said: "Before I came here I just existed, but now I am a person." He asked me if I knew the "turning point" in his life and then added: "When you became my caseworker." After telling me this, he became demanding and angry, and maintained that I never did anything for him. He wanted a car. Why wasn't I a psychiatrist? At one point he asserted that I was a "nice guy" but as a caseworker, "you stink." At another point he yelled at me: "Don't you realize that what you say affects my life? You make me sick. Every time we talk I go back to the cottage with an upset stomach and a headache."

That fall, four years after coming to the center, A began speaking of leaving and going home to live, "where school is easier." He started hypnotizing boys from my caseload. In psychiatric consultation I stressed the feeling that A seemed distressed about his feelings toward me and that aside from anger he somehow wanted to run from me. The psychiatrist pointed out that A was expressing homosexuality through hypnotism and was having a homosexual relationship with me by hypnotizing boys of my caseload. He needed to deny my importance to him and I needed to bring it out. It was felt that I should point out to him the defense and denial of his feelings. By so doing I would be supporting his ego and at the same time pointing out that it was one thing to have these feelings and another to act them out.

As I did this with A, he insisted that he was upset because I was a "lousy caseworker" and not important to him. I brought out that it was all right for him to have feelings toward me. If I weren't important to him I couldn't help him. Slowly he mellowed and said: "When I was a homosexual I used to believe I could not be cured. You told me you thought it was too early to tell and you thought I could have feelings toward girls. At first I didn't want to have feelings for girls, but now I have and maybe you can help others the way you helped me."

During that winter A continued to address himself to his leaving the center and to his future. He showed considerable concern about his inability to function on a higher academic school level. He was less sure that he could learn in school "if he wanted to." He became most angry at me whenever I pointed out that he had big ideas about his future but did nothing about them. For example, he spoke of going to college but didn't study. I questioned his desire to go to college. He insisted that he did and pointed to his parents' desires and expectations. When I wondered what his desires and expectations were for himself, he showed confusion and anger. I had, consistently, to separate him from his parents and to emphasize the importance of formulating his own goals according to his own needs and desires.

What was most noticeable in his interviews from about the fourth year of treatment to his discharge after five and a half years of treatment was that his homosexual problem no longer became the focus of our discussions. I slowly moved from defining what was permissible (talking) and what was not (acting-out) toward emphasizing that the past could not be changed but that if he wanted to do something about his present and future, he could.

Significantly, during the spring before discharge, when he was particularly anxious about his feelings of separation from me, he said: "I'm afraid that you see me by by my past and as I was." He justified the changes that had come about in him by saying: "Each person has a pattern. If one is raised in a pigsty, he lives like a pig. I grew attached to my mother and I had problems. I didn't know another way of life. Then I came here, and I wanted to change. It wasn't easy. I had to fit into a different pattern, the right one. Lots of times I didn't think I could change, but I did, and now I've learned to do things that give me satisfactions. I don't have to slip back."

The summer before his discharge, A was active in the campus council. He also had but one more semester to go before completing high school. During the summer he went to his home community to be with his parents as his father had been paralyzed. A's mother brought considerable pressure on him to stay home and assume the "father-husband" role. In conflict, A returned to the center and began his final semester of school. He needed assurance that it was all right for him to plan for himself. I recognized that, as unfortunate as his father's illness was, taking on the responsibilities of the household was too much to ask of the boy. A took a part-time sales job in one of the local department stores; he felt he had to help his parents financially.

As he became calmer about the home situation, he once again focused on himself. He spoke of being able to enjoy "little things like people and everyday occurrences." He went on to say that he accepted the fact that he would "never be a very happy person." He spoke of graduation, and of going home to live and then on to college at the start of the fall semester. At one point he said: "Don't worry. I'm not going to stay home indefinitely. I'll go to college and then the service. You see, I am really thinking of myself."

A few months before discharge A addressed himself to the changes that had occurred during his five years of treatment. Interestingly, he summarized: "I knew reality but I didn't want to change. I did it for you, but I think the environment may have been just as important as you. It's like one big experiment all mixed together, and it came out well. One thing

I can say for myself: I think I like life, and that feels good."

At the time of his graduation, during one of his last talks with me, he summed up his treatment: "There are three things that happen to a kid in treatment. First, he needs to be removed from the environment that was making him unhappy. Second, he comes to the center where he is shown new ideas and a better world. And third, he has to want to change. But once he is shown that he has problems, he usually wants to change." He ended by telling me that what he wants most in life is "knowledge" and that only by "learning" does he truly think he'll ever be "happy."

It would be deception to conclude that A is now "cured." His problems around aggression, sexuality and inadequacy continue to plague him, but his ego has developed sufficiently that he can cope with these conflicts and use his abilities more adequately. It is very likely that at some later time in life he may very well need additional help and treatment.

At the point of discharge he had become quite the "lady's man" and enjoyed a more comfortable social relationship with girls. As he became involved with a particular girl, however, he frequently or eventually dropped her, feeling he couldn't trust her.

His fear of rejection by girls and women often provoked him to reject them as a means of defense. He sensed the capacity for love and the potential to give within women but feared the possibility of their withholding or withdrawing love. Whether he could work this out sufficiently to make an adequate adjustment remained to be seen.

A came to the treatment center consumed with hate and guilt. At the time, his homosexual acting-out was an attack against all the deprivations and injustices that had been inflicted upon him against his will. Each aggressive sexual act only increased his guilt and created further anxiety, necessitating further acts and additional guilt. Such a socially unacceptable and threatening symptom brought on considerable environmental hostility for him. He was in desperate need of love, acceptance and understanding, and the symptom of homosexuality was, in a way, a defiant act and manner of gaining love at any level, as well as a symbol of his tremendous castration anxiety and the fear of taking on a more masculine role. It is interesting that his homosexual partners were invariably younger boys (about his brother C's age). Because C as well as his brother J and sister B were so favored in A's mother's eyes, is it any wonder that A sought what made the younger ones, particularly C, so loved, adored and acceptable? At the same time, he could hostilely bring his brother and all "younger brothers" down to his level (which, according to A's self-image, was of the lowest form).

Perhaps the greatest all-encompassing quality which prevailed within A was his engulfing feelings of unending loneliness. He was in frantic need of a relationship, one that could accept him and maintain social standards which gave him the control that he lacked and longed for. The giving up of the symptom was more than he bargained for but it became possible because of his desire to please a loved adult. In attempting to control his acting-out, he became noticeably more anxious and conflicted. His ability to suppress and later repress these impulses began to increase, however, and his inner controls became effective in coping with outer stimuli. With the ability to control came stronger feelings of enhanced self-worth and confidence. Having an opportunity to express his anxiety, fears and self-hate not only alle-

viated the pressures and served cathartic purposes but enabled him to rebuild his defenses and redirect libidinal energy into culturally acceptable modes of behavior.

It is interesting to note that the facing of the homosexual symptom and the conflict concerning it led to discussion of A's basic feelings of hate and retaliation, which he harbored and repressed against his parents (particularly his mother). What emerged was an overwhelmed, damaged child who had identified, to a great degree, with the aggressor (his mother) in order to avoid complete annihilation. He had endowed her with magnitudes of power and even admired this all-powerful force which had become almost a monster in his life.

On the other side of the coin was his anger at his father. He looked to the male of the family for the protection he sought from his mother, but he found an uninvolved, passive, frightened man who allowed the mother to rage and lash out without stopping her. To A, this could only mean further rejection and abandonment.

In treatment, the caseworker played a constant and consistent ego supportive role. At times he became the target which absorbed the anger projected and transferred on to him by the boy, whose hate needed to be released and accepted without retaliation. As A began to see to whom his hostility was directed, he began to bring his parents, especially his mother, down to human-sized proportions. Slowly he learned that women were not necessarily female Cossacks who flung sabres about on helpless boys. This became most evident when he began to relate on a closer level to his female resident cottage counselor, a kindly, intelligent, non-threatening, maternal woman. This was not done without months and even years of testing intermingled with all sorts of accusations and verbal attacks. This was A's pattern in every attempt at relating. He needed to provoke and reject others because he himself feared attack and rejection. Even today he sometimes resorts to this method of relating, when he is limited by someone in authority or when he senses his need for acceptance by a person in authority.

After years of testing the counselor, one day he told her: "Do you know that you and my caseworker are the two most important people in my life?" At that point he endowed the counselor and caseworker with all the qualities that he felt lacking and that he wished in his own parents.

A crucial point in A's treatment was when he re-enacted through his worker the homosexual acting-out with his brother C, in the presence of his mother, by hypnotizing another boy when it had been defined (by the worker) that this practice was unacceptable. A was needing to re-live and undo this traumatic experience and was attempting to master it by repeating it. According to Thompson:[2] "In the transference, the patient repeats his childhood experiences, both good and bad. It is further observed that not only do people tend to repeat earlier life situations in the transference, but there is a general tendency to repeat life patterns over and over again. Human behavior is dominated even more powerfully by the tendency to repeat former patterns of life than by the pleasure principle." With the re-enactment A was finally able to see that the adult was interested in protecting him and wanted no harm to come to him. The worker did not condemn and reject; instead, he limited A's action because of his concern for A's well-being, which to the boy was an in-

[2] Thompson, Clara, *Psychoanalysis: Evolution and Development.*

dication of love and acceptance. What followed was a recognition on A's part that he had done things behind his parents' back that made him feel "bad." He now felt that he no longer needed to resort to this pattern of behavior. He was now freer and able to use his resources much more adequately.

At no time in treatment did the caseworker interpret to A the boy's fears of castration, homosexual-masturbatory or incestuous fantasies. Such an interpretation would generally be avoided in casework. (The caseworker may not be able to select his clients but he can be selective in how he deals with them. A variety of casework approaches can be applied.) Instead, in this case the worker chose to provide casework that was ego-supportive, on the theory that this had much to offer an adolescent whose primary symptom was homosexual acting-out. It was an educational process in which the worker held up reality to the adolescent and thus supported his weak ego. He pointed out the unacceptable behavior (homosexual acting-out), conveyed the feeling that the adolescent could control this, and supported him when he did show control.

For example, to bring the homosexual acting out of A under control and to bring his anxiety to the surface, the worker had to take a definite, firm, non-punitive stand based on his concern and his desire to protect. To have been indefinite and noncommittal would have been permissive and would almost have encouraged further acting-out. Such an approach might unconsciously have meant to the adolescent that the worker lacked standards, and eventually the acting-out might have become a delinquent interplay with the worker. By being firm and insistent, the worker practically coerced the adolescent into facing his anger, hate and anxiety. A, was given confidence through the relationship and as a stronger ego developed, he saw that he could function successfully in many areas (as a campus council participant, athlete, cottage leader, student, salesman, etc.).

Empathy and acceptance were also important. A needed to know and understand that the worker was aware of the existence of his feelings and of how difficult they were to live with. As treatment progressed, the worker focused on the concept of self and supported the healthy part of the boy's personality. He helped him to see his separateness, to evaluate his parents more realistically, and to see, first through the worker's interest and then through other relationships, that he could be liked.

Today A manages to live with his parents and is about to enter his freshman year at a state university. There is every indication that he will be able to make an adequate adjustment to life. However, if his problems again overwhelm him, he has strengthened himself enough to know that help is available to him and he will seek it.

In such a case, psychiatric consultation helps the caseworker to understand the diagnosis, to delineate the problem and the dynamics involved, and to set realistic goals within the framework of casework methods. The casework supervisor guides the worker toward helping the adolescent learn to accept his parents, to emancipate himself from them, to develop a concept of self and to use his potentials. This combination of effort—psychiatric consultation, casework supervision and casework—brought this case to a successful conclusion.

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JOOST A. M. MEERLOO, M.D., PH.D.

Psychological remarks on the East-West controversy

Directing my thoughts and experiences to a gathering of creative writers, I feel like an intruder from a different world—one who speaks a different language, who uses different tools of communication and expression, and must grope very carefully for means of *rapport*.

I am not adept in the careful research and questionnaire techniques of professional sociologists. Neither do I have the sophistication of anthropological field workers. I am only a guest from a friendly faculty who can tell you what his clinical experiences have taught him, and what psychology can teach us about the differences between East and West. I am not so modest, however, as to pretend that descriptive clinical experience cannot lead to usable insights. I hope that you will appreciate better the historical approach of clinical psychologists, which I hold equal in value to the experimental deduction and reduction of facts sought for by political scientists and the intuitive findings written down by creative writers.

There are various ways to approach the mysterious gap between Oriental and Occidental thinking. I want to place my personal contact with people from both cultures in the centerpoint of my ponderings.

I invite you to dwell with me in the psychiatric consultation room and hear and observe what Eastern and Western man have taught me about their inner and environmental problems. You will have to pardon me, however, if I express myself

Dr. Meerloo, a practicing analyst and psychotherapist in New York City, delivered this address in September 1957 in Japan before P.E.N., an international organization of writers, and before convocations of the Universities of Karachi, Colombo and New Delhi. The theme of differences in ways of life in East and West was introduced as part of a general study project of UNESCO.

in typical Western idiom and if I cannot rid myself completely of some abstruse psychological terminology. Even the expression "East-West controversy" is part of a political myth involving the twain that shall never meet. The semantic origin lies in British colonialism and ancient British Discrimination.

My only justification for an intrusion into the more direct, visionary approach of the creative writer is that I have had the privileged opportunity of having intensified contact with people from opposite zones of the earth. This experience led me to believe that much that looks so controversial is part of a pseudo-problem and an artificial psychic facade. Working as a psychologist in New York—the melting pot of so many races—gave me additional opportunity to evalute the universal human side of the problems involved. We psychologists are proud that the latest decision of the U. S. Supreme Court in 1954 on the legal equality and even opportunity for different races was based not on juridical but on psychological arguments.

Intensified personal exchange on various human values gives us the opportunity to express cultural controversies in the general human qualities which all people have in common. What usually keeps people apart is not what the other man essentially is, but the traditional stereotyped image—mainly of a negative sort—which each man projects onto his fellow man. Projection is the key word. Yet these mutual allusions and projections are difficult to correct.

One of the roots of our common bias is the general narrowing in thinking and awareness that takes place the moment we identify with our own group or with a special race or nation. The psychic fact that we belong somewhere—to a family, to a class, to a social formation with a different label—unwittingly provokes in us the inner need to identify with a limited standpoint or ideology and to betray our sense of reality and objectivity toward others.

I had the good fortune to spend my ripening years in a neutral country—Holland—during the First World War. I enjoyed the guidance of a beloved professor in philosophy who taught us his concept of biased thought limitation. In those days the propagandistic words from both warring parties tried to catch our ears and minds. Of course, we chose our standpoint and became partisans but were not completely able to drop our teacher's concept of the unconsciously narrowed view.

Subseqently I went through the Second World War and the pains of destruction and occupation and was forced to escape from my fatherland to save my life. To repeat Stefan Zweig's words, I felt that I had no courage any more to be objective and just. For years my need to understand the other party—the enemy—disappeared and I spoke with words of bias and with melancholy disillusion about the general decline of humanity.

Yet all this could not destroy the once-experienced urge for benevolent objectivity and for enlargement of view. We all—I included—have our peculiar thought prejudices and brain limitations when special, sensitive subjects come to discussion. Then we are nearly automatically forced not to think for ourselves but to identify with special groups and their collective thoughts and to jump into various defensive attitudes because we want to belong somewhere. We all have different skins and different ancestors and we speak our prayers—or ideologies—in different ways. Our arguments and counterarguments lie ready not to prove the logic and objectivity of our reasons, but usually to serve as secret partisans of a general human hostility and aggression. It is so easy to pro-

voke those inner partisans and to let them dominate our discussions. They give release to anger and pent-up tensions but at the cost of better understanding.

So we may ask ourselves here: What is our aim? Is there an unobtrusive wish to put our cultural and racial differences to the fore or do we search for the tension-reducing goal of mutual comprehension?

THE WORLD BATTLES ON MANY FRONT LINES

The great clash of human opposites in our world has become increasingly apparent within the last half-century. Recently some of its facets have come into even sharper perspective. The implications of this spiritual and material clash are worth describing only when they can be made clear to each of us. It would be futile to speak of differences between the Eastern and Western psyche without realizing that psychological opposites are never exclusive, that their very roots are found within each human being. (In a book dedicated to the innate antinomies of man I could elaborate on this subject.)[1] At present we find ourselves, through political and social-psychological implications, bluntly confronted with the emergence of contrasts which are explained as merely racial or political while they are in fact part of the more general and universal make-up of man.

The East-West problem has become even more urgent since the relations of the big powers have changed our actual world. The Second World War pushed western Europe away from the world hegemony. America and Russia and Asia emerged as the more powerful forces with all the risks of their new responsibilities.

The solution and integration of some of the actual contrasts will have world-wide consequences. Small signs of these psychic difficulties are already apparent. These signs haunt us like shadows day and night right within our own homes when we discuss, for instance, the problems of the rumbling Middle East with its fervent fanaticism and the Asian battle cry against colonialism and discrimination. Let us not forget, however, that the development of a more intensified free democracy in the West helped to conquer the egotistic and biased concept of paternalistic colonialism among the Westerners themselves. The terms "colonialism" or "colonial symbiosis" or "colonial drainage," often used now, are as much biased—covering up feelings of inferiority—as words like "racialism" and "capitalism."

Oriental culture has generally been much more aware of the circle of bias and warped realization in which men are caught. Occidental pride too often forgets that its very picture of the world is a mental construct, conditioned and biased by the social institutions it tries to conceive and explain.

Yet we are forced to strive ceaselessly for harmonious integration and cooperation. What are some of the actual major problems involved? In our world, several —and that means a multitude—internal and external battles are being fought: hot wars and cold wars, ideological battles, delusional fights. Each side vies with the other for our favored support. It is important for us to be aware that the world battles at *many* front lines and that the East-West contrast is only one of them.

The contrasts in our world center only partly around the battle between freedom and totalitarianism—that nasty battle between individuation and conformity to the various party lines. The battle for greater social conformity and participation is

[1] Meerloo, J. A. M., *The Two Faces of Man*, New York, International Universities Press, 1955.

fought in all cultures where mechanization takes command. Other contrasts are the wars between capitalism, socialism and communism as economic systems and, beyond that, mechanization and technology battling with natural adjustment, moralism struggling with pragmatism, new chauvinistic superiority feelings struggling for ascendancy over national and racial inferiority feelings. We can also discern an idolatrous worship of the collective power of the masses. Through it all we see a cold intellectualism grappling with spontaneous creativity. There is the terror exerted by minorities battling democratic freedom. There is the tendency to rigid discipline over the masses grappling with that innate urge of the individual for rebellion and freedom. Even the farmer and his city cousin are in conflict; they are the symbols of man's agrarianism opposing his hovering urge for urbanization to protect his feelings of insecurity. Indeed, many battles are going on in our actual world.

Though many contrasting ideologies can be mentioned, none is limited to one special group or nation or geographical area. The contrasts are seen to cross various geographical areas. Especially in the study of the East-West contrast one finds that people everywhere have built up their huge constructs of thought. Many of those systems are nevertheless comparable with each other; throughout history people have grappled with the same problems. But it is especially the speed of development of our technological era and its illusion of a quick earthly paradise that is one of our greatest concerns now. It has done tremendous damage to the development of vital and unconscious forces in man, while its destructive potential far exceeds the integrative forces of the human spirit. But let us not forget that this very technology, this typical product from European soil, will be able to feed the masses and free them from disease and poverty—though we will have to pay mental pains for this material gain. Yet the Orient taught us the wisdom of renunciation and ascesis and the deep scepsis about every form of material gain. It taught us the prevalence of psychic and spiritual forces, while its antinomy—the technical age—preaches to us of more and more material want and the need and urge for greater luxury, resulting in man's passivity and the fear of losing what he's acquired.

KEEP SILENT, MY FRIEND, KEEP SILENT

My friend, the oriental psychologist, if he were asked to reflect on differences between the Eastern and Western psyche, would smile about the attempts of an occidental to write down in ambiguous words that which cannot be easily expressed. My Japanese friend would say: "Why don't you Western men seek more happiness in our oriental principle of tranquil stability? The integration of East and West will undoubtedly be established in the future, but not by one of your restless searchers for so-called objective truth and understanding. So be quiet with us; let our thoughts flow freely in limitless meditation and listen to what the intuitive voices within us will reveal to us."

"But aren't you aware of the urgent problems in the world?" my occidental haste and impatience would prod me into asking. "Eastern and Western armies are steeling themselves against each other! At any moment a shooting war may start again!" And then I will very defensively bring my own anxieties into the argument with many redundant cliches such as "colonialism . . . atomic doom . . . communism . . . the turbulent Middle East . . . the

decline of occidental culture and the decay of many other things."

My friend would only tell me: "East and West go with you where you go and are everywhere different. Don't you create your crystal-clear problems to hide the deeper and more obscure ones?" my friend, the oriental psychologist, would continue.

And then only silence would follow.

EAST AND WEST IN THE THERAPEUTIC HOUR

Nobody realizes better than the medical doctor that men are fundamentally equal. They come to him with identical pains and problems, with the same sadness and ecstasy. Man falls in love; children are born; a man dies.

When I first met a Chinese patient for medical and psychological treatment I expected a great many difficulties. My not-too-precise knowledge of oriental culture had not only inspired me with awe and respect for our oldest existing civilization but had also given me a feeling of strangeness, of something eerie that my mind could not grasp. Contact with people from the Far East, during a medical trip to their region, had always been on a formal basis—with that ritual of mutual politeness that leaves an emotional vacuum between people. We could talk about facts, even the facts of different religions and philosophies, but all the while our hidden thoughts were: "Please don't touch our private emotions and prejudices, and let us not intrude into subtle personal feelings." In addition, anthropologists had warned me about the pitfalls of cross-cultural studies and comparisons. They especially cautioned me about the too utopian view of the Far East and the idealization of the oriental aspects of life.

However, my expectations proved to be completely wrong. The psychological treatment proceeded in exactly the same way as with other patients, though from time to time there were semantic difficulties because we were both obliged to communicate in a language that was not our own. Yet the old, eternal human problems were the same: a childhood with difficult parents, a harsh school in a country torn by war, rivalry with an older brother, the loss of the beloved bride. Here was the same outpouring of the crying child that I had experienced with other patients. Everywhere people experience the same eternal problems: the inevitability of death, the creativity of love, the deep search for freedom, the fear of the unknown. My Chinese patient told me about his peculiar background of oriental rites; it was always a pleasure for him to explain to me this exotic, unfamiliar world and to tell me what was essential or what part belonged to traditional rites. Yet it was the intense human contact of our explorative collaboration—you may call it transference—that helped him to solve his conflicts.

Later I saw patients from Java and Japan, and we met each other in the common field of universal human conflicts. Basically people are the same and understand one another in their needs. We were born in different cultures, we spoke different tongues, our historical backgrounds were different; nevertheless, we understood each other on the basis of mutual goodwill.

Why then man's preoccupation with racial, cultural and national views so easily leading to nonunderstanding and the furthering of mutually hostile feelings? People forget all too easily that we all are *involuntary* members of our particular national and racial groups. By birth we are compelled to belong to them, and this fact unwittingly obliges us to develop partisanship, bias and also certain loyalties regard-

less of the inner conflict we come to feel about this.

VARIETIES OF CULTURAL BREEDING

When we can accept the fact that men do not differ much in their basic physical, psychical and spiritual needs, it remains for us to discover what has brought about the fiction of unbridgeable racial and cultural differences. Could it be, for instance, that at one spot on Mother Earth one aspect of man has been more bred and cultivated and that at another spot a different human quality became emphasized? Psychology teaches us, however, that this very variety and differentiation of human aspects and qualities develops in every community where people live together; the latitude of qualities in one group is often greater than the mean differences between groups.

Everywhere when two people meet each other in a state of common immaturity a subtle hostile strategy takes place of mutual probing: who is the stronger one, mentally or physically? This strategy of expansion, trial domination and personal "colonialism" between individuals started with Cain and Abel and is still part of the power politics between individuals and nations.

Every single man is built up with a framework of various contrasting principles living within him. In every group a strong man gradually gains a dominant position as leader, causing his qualities to be an example for other members of the group. The special aspect or character of the group is greatly influenced by a common identification with the leader and his outstanding qualities. Multiply this principle of coincidental domination of specially outstanding human aspects and variations within a group by several millions (the members of any given civilization) and multiply this outcome again—to comprise the various character types appearing within various groups in the course of many generations—and you will more easily accept the great variety of patterns into which the common human reaction-basis can branch out. Yet, surprisingly enough, the number of essential cultural patterns is a limited one while usually the variety of psychic patterns inside one group is much greater than the variety of mean characteristics of groups themselves.

Roughly, I consider a cultural pattern of totality of learned and imprinted behavior shared with members of the group and partially acquired from historical traditions and patterns, partially from new adaptations during one's own lifetime.

The psychological fact that internal variations in a group are much greater than external variations is often neglected in order to retain the need to be biased and to find scapegoats for the qualities one hates in the in-group.

When the various cultural groups look at one another with all the astonishment aroused by their differences and with all their pent-up old patterns and prejudices, it is difficult indeed to accept the thought that behind the divergent cultural developments identical hearts are beating and similar feelings are experienced. It is difficult indeed to break this myth of unbridgeable contrasts and to conquer our prejudices about irreconcilable conflicts. Communication between disparate groups seems nearly impossible because gestures, sounds, symbols and words seem to be different.

Loaded words, such as *race* and *blood* and *color*—which belong among the political catchwords of the last fifty years—have become much more the tokens of deep-seated prejudices, of bursting aggressive

drives, than of objective reason and scientific meaning. Yet these words are only the outer aspects of our stereotyped images of different cultural types.

Each one of these cultural groups, however, has a more immediate means of communication that may lead us more directly to the core of mutual understanding and intuition and that can break through the old patterns of fear and suspicion, of dread and drudgery. It is the universal expression through religious symbols and through creative art. Through the avenues of creative expression we can comprehend and empathize the religious and moral feelings and even the philosophy of those who otherwise live mentally remote from us. In this search for comprehension the East is much more direct, ideographic, working with the psychic instrument of intuition; the West is indirect and analytic, working through the instrument of connotation.

Yet the hurried psychologist in us wants all this diversity to be expressed in precise and formal technical terms of human behavior. He asks prematurely: What is the psychological motivation behind Confucius, Buddha, Islam or Hindu philosophy? Or, he may ask, to stay nearer to base in asking: What deep-seated mental complexes divided Christianity into so many different denominations and how can we integrate these schisms?

In the next part of my study I want to survey the principal thoughts about the East-West controversy that came up in actual psychology, though I am aware of the risk of modern psychology in trying to formulate problems that perhaps are not real problems.

SEARCH FOR CONTRASTS AND DIFFERENCES

The fallacy of describing psychological differences between East and West is that we tend to interpret them in a biased way as contrasts rather than as a more or less pronounced dominance of certain human qualities and patterns that never were completely alien to our own culture and our own inner make-up. Wherever you may be in the world, tension always starts within the individual human being. Even our concept of "the oriental psyche" is a fallacy because there are as many variations between Chinese and Japanese or Javanese and Hindu habits as there are among individuals and groups in our Western culture. Yet some principal aspects as we experience them in a rashly changing world can be tentatively distinguished. Eastern man stays closer and with greater intimacy to his family group and his community. His need for discretion and reservedness, for self-distinction and privacy, for feeling his own separate inner authority is usually differently developed than in the Western world. The oriental need for being alone, in isolation, is much more part of a religious ritual in the service of concentration and meditation. Yet even in his lonely ritualistic retreat oriental man identifies with and remains part of the group.

Ruth Benedict calls more intensive group participation the core of the oriental psyche. She makes the appropriate distinction between Eastern *shame* cultures and Western *guilt* cultures. Shame and guilt are different feelings. Shame, or losing face, or feeling humiliated, is man's reaction to criticism of (and minimization among) one's own family and peers. The individual in the shame culture is and remains—much more than the Westerner—a participating member bound to his original social group. His group prescribes how he must restrain himself and what character quality he is to suppress in order to be more acceptable to the other members. Social conformism is their aim. The

individual can be rejected by his group, or ridiculed, or he may even fantasy that he made himself ridiculous. The point is that he virtually never steps out of the compact group relation, the family, the clan, the nation.

Yet I must confess that we can more and more observe this form of development of the "group-related man" in our Western institutionalized technological society. It is as if Western society moves more towards the Eastern pattern of common participation and greater conformity. Is the West forgetting its typical Western ideas: the idea of strong self-consciousness, the idea of individual freedom and the idea of the unique individual personality? Is it the intrusion and impact of the organized masses on individual thinking and personal liberty that made us have an inner uproar and accept better the concept of the Oriental psyche?

The Western concept of personal guilt and responsibility makes the individual assume a greater distance and isolation from his group. Here the individual's principal conflict is not with the group but with his inner self. Nobody else needs to know about this deeply hidden inner struggle. Man and his judging self, man and his superego or conscience, are in conflict.

In Eastern thinking, guilt and punishment belong more to an impersonal world-law, *Karma,* that gradually leads man to final purification after many reincarnations. Eastern theology is more pantheistic without the need for either a diyine and superpersonal judge or an internalized judge which we call man's individual conscience.

In contrast to the group-bound individual in Eastern society, our Western society burdens the individual not only with restraint from unsocial behavior but, beyond this, with a deeper restraint and repression of his unsocial drives—as if they no longer exist in him. Western man has to ban his feelings of hatred and destructiveness for the greater part from his consciousness, in order not to be plagued by feelings of guilt and loss of self-respect. His hypocrisy is much less conscious.

However, as said before, we discover in our Western world various transitions between this group-related and ego-related man. The so-called "organization man"—the product of our technological institutionalism—behaves more and more according to the Eastern participation pattern. His life belongs to the corporation and the institution, as if continually directed by conforming evaluations.

The anthropologist, Dr. Francis Hsu, expresses some psychic difference between East and West through his appropriate distinction between the Eastern suppression culture and the Western repression culture, in which repression represents the deeper frustration of drives. In his study on the interpretation of four cultures he gives, as an example, different attitudes toward sex. Oriental culture uses the pattern of group-directed social restraints. The suppression of sexual and aggressive drives is predominantly under the control of the group, in order to fit the individual into his culture. There is less sexual taboo and embarrassment. The West emphasizes the individual inner battle and the deeper repression of instinctual drives toward hidden unconscious regions of the mind and controlled by an often overburdened personal conscience. That is why the idealized play of romance and love acquires such an important role in Western artistic creation. Continual idealization and sublimation has to placate the burden of sexual aggression and repression resulting from so many taboos. The oriental suddenly placed in our American way of life feels surprised and amazed about our dichotomy of sexual

morals—the puritanistic repression at one side and the luring and seductive advertising at the other side.

We may say that occidental development, more than its oriental counterpart, went in the direction of greater individual isolation and distinction. I use these words—isolation and distinction—to indicate that there are two sides to the coin. Western man becomes the introspective, soul-searching being, feeling isolated even from his own family, confronting reality with a critical, hyperintellectual view, and morally responsible for his feelings to an inner deity, his conscience. For this social and moral isolation of the individual, the occidental world has had to pay heavily with frustration and neurotic development. I believe that it is this hyperindividualistic isolation of Western man—living, so to say, in an emotional vacuum—that stimulated the tremendous interest and growth in psychology in the West.

The inner psychic tension provoked by the greater repression and frustration enforced by Western society resulted in greater feelings of hostility toward strangers and foreigners—though incidentally, anti-colonialism and anti-tyranny may arouse the same aggressive passions in the orient. Strangers and outsiders usually represent, for oriental and occidental man alike, evil qualities that have to be inwardly conquered, repressed and expelled from man's own psyche. Racial prejudice and segregation, for instance, usually symbolize the outwardly directed hatred toward what we hate in our own souls. It is an expression of deep feelings of inferiority which ask for time and tolerance in order to be cured.

Oriental civilizations have been, in general, more receptive and hospitable toward other cultures and races. They are not so interested in the historical philosophy that has to justify the uniqueness of their existence. China is the classical example. It lost its wars but won the occupiers: the victorious invaders from Mongolia and Manchuria became Chinese. Hindu religion looks at all religions with universal tolerance. It preaches the unity of polyform beliefs. It even accepted very early the modern physical principle that conflicting theories can be true at the same time. Yet while Hinduism was tolerant of the differences in spirit and preached a religious individualism, it proved to be intolerant of the pariahs, the people of the lower class.

That is perhaps the reason why Islam at this moment has its strong impact on the illiterate masses. The doctrinal uniformity of Islam, with its philosophical equality and urge for action, appeals to the group-directed man. The poet and Moslem philosopher, Iqbal, reproached oriental thinking for its passivity and its emphasis on contemplation. The Mohammedan uniformity of doctrine and its psychological patterns of participation may, however, make the Moslem world more vulnerable to totalitarianism.

IDEA OF ONENESS CONTRA SEPARATENESS

The oriental ideal of man, as we find it in Japan and Buddhistic countries, is in the first place that of unity and oneness, of being one with the family; one with the fatherland; one with the cosmos; one with nirvana. According to the oriental ideal, subjective man merges and identifies with the cosmos in intuitive images. The oriental psyche looks for a direct aesthetic contact with reality with undefinable empathy and intuition. Individual man is a small part of an aesthetic cosmic mosaic. Eternal truth is behind reality, behind the deceptive veil of Maja. Man is part of the universe, serving the ideal of passive resigna-

tion and ecstatic equanimity. His peace of mind is found in rest and relaxation, in common meditation, in being without manual and mental travail. His happiness is born out of the ecstasy of feeling united with the universal cosmos. Asceticism, self-redemption and poverty are still ideals in oriental culture.

The Western ideal of man is much more individualistic and distinctive. Occidental man is the rebellious Lucifer confronting the universe with his own individual self. He builds up subtle ego defenses behind his mask of imperturbability and manipulates reality aggressively with logical deductions and abstractions. In his analytic approach he seeks to reduce the cosmos to simple causal laws. He looks at unity not as a unity of all that is alive in the universe but as a unity of concepts. He wants to become independent of his teachers, eagerly trying to bypass them. Eastern man, however, wants to remain with his teacher; his *guru*.

Occidental man fears the mystic and the irrational; his is an analytic mind. That is why he is so preoccupied with the fear of death and the great unknown. He looks for outer luxury and enjoyment without expecting too much inner happiness. He talks about happiness but does not feel happy. Only the devoted and dedicated artist among Western men reaches the ecstasy of creation. The technical perfectionism of Western man may degenerate into a megalomaniacal delusion of power driven to the point of atomic destruction. In the raving frenzy of a motorized holiday many a Western man already anticipates and accepts this token of technological death.

A Westerner's peace of mind consists of maintaining the harmony of a tense inner equilibrium. The Eastern psyche is looked at by the oriental as an expression of cosmic powers in man, the microcosmos, while Western psyche is interpreted by Western psychologists as the summation of attitudes in the individual leading to cognition and understanding.

The common need of man to belong somewhere, to have contact, to participate with others and to form a living community is solved in a more direct way by orientals than by us. While orientals fit themselves more easily into their environment—the family, the caste, the class, the nation—we Westerners do this through the medium of a fetish: a membership card, a diploma, a church label, a marriage license. The oriental in his ancestor worship has a vertical relation with his fellow men rooted in family and tribal traditions. He is a link in a historical phalanx.

The occidental has a horizontal relation, imprinted on him by the accidental labels and diplomas he wears. Our Western integration into groups is often expressed more by the official labels and sectarian names we wear than by true feelings of belonging. Even when people are sitting together watching the television screens, these Westerners are isolated, lonely individuals soothed temporarily by a sensational or an aesthetic program for which they have given up communion and conversation with their children and their friends. Not enough group life is left to ease inner tensions.

Oriental man maintains less distance from the group into which he is born and less distance from his environment. His need for discretion and reserve, for self-distinction and privacy and for having his own inner security is not so extremely developed as that of the Western soul. Living in tune and in harmony with his actual world is a true oriental ideal.

SHALL THE TWAIN EVER MEET?

Whether East and West can meet is not the real problem any more; both technology and the cult of individualism penetrate into the East; and the West goes back more and more in the direction of participation and greater conformity. Yet can man meet man? Can left meet right? Can poor meet rich? Can the gay meet the sad? This is the real psychological question. The problem arises as to whether those who live withdrawn and isolated can meet those who live with their hearts on their sleeves. Are there new universal messages that can fill in the ideological vacuum of our technical age? These are universal problems for both East and West, for Left and Right.

Basically the same mental and spiritual drives live in everyone, but in each individual the patterns and mosaics are different and there are various cultural histories, traditions and ideals to identify with. What keeps people apart is not what the other man essentially is, but the traditional stereotyped image each man projects onto his fellow man. Our upbringing and the impact of the cultural traditions and suggestions encompassing us are so powerful that it is nearly impossible to have an unprejudiced look at our fellow man. Because of different emotional aims (conscious and unconscious) the various groups and cultures create obstacles in the path of mutual understanding. Psychologically, hatred and nationalism are nearly always fabricated by resentments and dark drives of a terrorizing minority. These passions may be aroused by minorities inside the group or through contagious propaganda imported from outside.

The problem of improved relations, coexistence and intensified communicative interplay between different cultures is in the first place one of understanding and comprehension of common moral aims. This is not a matter of continuing to try in an impractical, idealistic way to teach and berate each other, but of asking ourselves repeatedly: "What keeps other people and us so stubbornly prejudiced against mutual understanding?" In personal and in collective history we observe that differences in religious and philosophical concepts are misused to justify aggression and persecution. They are never the real causes but serve to cover up man's quixotic search for aggressive outbursts and for power and wealth.

It will take considerable time and a great deal of education and exchange of thought to correct the various internal stereotyped pictures people have of the Chinese, the Russian, the Communist, the Nazi, the Parisian, the Arab, the Jew, the Mexican, the Japanese, and so on. There remains for each of us the urgent and crucial question: "How can we possibly change these prejudiced impressions and images we have of one another?" How do we, in our divided world, fight the battle against sacred superstition? Mere diplomatic and official exchange of books or students cannot help enough in this problem, and the cold war with its hostile propaganda barrage succeeds only in transplanting the wrong images and in fortifying mutual hostility and prejudices.

Cultural and educational exchanges can be a better means to help people learn to understand what is hidden behind the racial and national masks we all put on in human contact. Reluctantly, however, I have to agree that such exchange can also serve as mere chauvinistic propaganda. Better means than these must be found to overcome the mental barriers of geographical and racial prejudices.

The crux of the question is how to familiarize the great masses of people throughout the world with the general and

universal man in each of us, the human and responsible man we all have in common. How can we give people a new and vibrant feeling of identification with the universal and common citizen of the world called *homo sapiens*?

One of the chief problems in our world is the establishment of a science of tolerance promoting the growth of man's moral capacity to tolerate each other. Only such an applied science and art will be able to neutralize that other tendency in our actual world created by the growth of material wealth—namely, the organization of dissatisfaction and resentment. The latter propaganda for unhappiness is partly done in an unobtrusive way resulting from our technical development. Yet it is also used as a huge political weapon in the hands of totalitarian strategists.

In the new mondial education for tolerance, the international club of writers, the P.E.N., the United Nations and its special cultural subdivision, UNESCO, will have their most grandiose educational task. As a matter of fact, they are already working at this task, though at present on a rather small scale. Psychology, and especially the new science of mental hygiene, can be of much help in the new development of tolerance and positive peacefare, because it teaches us to empathize and to identify with the motivations of the other fellow.

Although the creative means of communication expressed in religious and artistic symbols already give us that intimate contact needed for greater mutual understanding, psychology—if able to use the intuition and empathy of the artist—has the task of giving it a more consistent and widespread impact. Believe me, much water will have to flow to the sea before psychology will have reached that clarifying vernacular.

In mutual identification, empathy and sympathy for the foreign man and stranger will grow. In the future the United Nations will have to do much more than it does now to reach the various isolated countries and bring them the images of other men, other cultures and other voices of humanity. A more ideal U.N. will be not only a central organ of diplomatic and scientific and cultural exchange but will reach out and build its own cultural representation and center of exchange in the different countries. A new image has to be built up: man as the universal citizen of the world. He will be shown in his manifold cultural aspects, not only in all his differences but also in all his similarities. What a challenge for writers possessed by this ideal!

Tentatively we may say that the pattern of participation and conformism we talk so much about gives, at a juvenile level of development, greater feelings of comfort and security. At least one belongs somewhere. Yet, at a more mature level, it robs people of dignity and reserve, of self-confidence and the feeling of being a free-acting unique entity.

I am sure that future psychology will speak no more of essential differences between the Eastern and Western psyche, but of their different and separate developments and what mankind as a whole can learn from these. Only the integration and impact of both cultures will lead to an intensified understanding and enhance common creative endeavor. Westerners with their accumulated intrapsychic tensions, with their pattern of individual isolation, could learn so much from the more accepting equanimity of the Eastern psyche. The more resigned and self-denying Easterner, with his pattern of greater participation, could take over part of the proud independence of Western individual-

ity. Both the orient and the occident will be enriched by greater mutual identification. Then we may repeat with confidence the well-known lines of Kipling's poem:

"But there is neither East nor West,
Border, nor Breed, nor Birth
When two strong men stand face to face
Though they come from the ends of the earth!"

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HOWARD E. FREEMAN
GENE G. KASSEBAUM

Relationship of education and knowledge to opinions about mental illness

Community programs to increase the public's understanding of mental health problems often are based on the assumption that attitudes toward mental health are linked to level of education and knowledge of psychiatric concepts. Thus, mental health education stresses giving people the facts about mental illness. In this paper we present data which do not support the assumption that opinions are linked to knowledge. Two questions are examined: Are opinions regarding the etiology and prevention of mental illness related to the level of formal education? Are opinions regarding the etiology and prevention of mental illness related to knowledge of the technical vocabulary of psychiatry?

METHOD

The data for examining these questions were obtained from a survey of the public's conception of mental illness conducted in 1950 by the Washington Public Opinion Laboratory.[1] An area probability design was used to select a sample representative

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[1] The authors are most grateful to Prof. Stuart C. Dodd and the Washington Public Opinion Laboratory for providing us with the raw data. We, of course, are solely responsible for the analysis and interpretations herein. Preliminary tabulations of the survey were analyzed by the late Lillian B. Patterson of the University of Washington. A mimeographed report titled "Preliminary Tabulations on Mental Hygiene Poll, interviewing November, 1949," was published by the Washington Public Opinion Laboratory. We wish to note that the data were not specifically gathered to answer the questions discussed here.

TABLE 1

Variables included in the analysis

VARIABLE NUMBER	ITEM
1	Do you believe it is possible to prevent mental disorders?
2	Do you believe that people who have mental disorders get well again?
3	Do you think most mental disorders develop gradually or suddenly?
4	Do you believe that cases of mental disorders may arise from lack of will power?
5	Do you feel that dissatisfaction with your job can help cause mental disorder?
6	Do you feel too much brain work can help cause mental disorder?
7	Do you feel alcoholism can help cause mental disorder?
8	Do you feel that the parents' attitude toward a baby during the first year of its life may affect its mental health later?
9	Do you think that juvenile delinquency is related to mental disorders?
10	Do you feel that constant nagging can help cause mental disorder?
11	In your opinion, can difficulty in getting along with one's family or with one's husband or wife help cause mental disorder?
12	Do you feel that financial difficulty in the home can help cause mental disorder?
13	In your opinion, can the menopause (change of life) be one cause of mental disorders?
14	Do you feel that difficulty in getting along with the people at school or at work can help cause mental disorder?
15	In your opinion, do mental disorders run in families, that is, can it be inherited?
16	Do you feel that alcoholism may be a result of mental disorder?
17	Knowledge of psychiatric terms (total number of correct responses to 32 questions such as "shock treatment using insulin is a treatment given for diabetes").
18	Confidence about knowing psychiatric vocabulary (total score of responses to 45 terms such as *neurotic, moron*).
19	Knowledge of psychiatric vocabulary (total number of correct responses to 30 items, such as *psychosis, senility*).
20	Recognition of neurotic symptoms (total number of correct responses to 18 signals—such as loss of appetite, depression—as warning signs of mental disorders).
21	Have you ever been acquainted with a person who had a mental disorder?
22	If necessary, would you go to a psychiatrist?
23	Sex.
24	Marital status.
25	Are you a veteran (World War II)?
26	What was your age as of your last birthday?
27	What was the last grade and year you completed in school?
28	Total household income.
29	In general, and as compared with a year ago, do you feel that conditions in the United States are better or worse?
30	In general, and as compared with a year ago, do you feel that the international situation is better or worse?
31	Rural-urban residence.

of adults living in the state of Washington. Of 500 planned interviews, 483 were completed. The interview consisted mostly of items requiring yes-no responses, although a few open-ended questions were also included. In our analysis all the items were used except for a few structured ones with highly skewed distributions and the open-ended questions.

The 31 items employed are shown in Table 1. The analysis includes 16 individual items eliciting opinions regarding the etiology and prevention of mental disorders; four variables reflecting knowledge of psychiatric terms; a question on whether or not the informant was acquainted with a mentally ill person; an item on willingness to go to a psychiatrist; seven items on social characteristics, including respondent's education; and two questions measuring optimism. The variables reflecting extent of technical knowledge represent scores on four different sets of items: variable 17 is a true-false vocabulary test of the understanding of psychiatric terms; variable 18 measures the respondent's confidence regarding his knowledge of these terms; variable 19 is a multiple-choice vocabulary test; and variable 20 is a multiple-choice test of the recognition of neurotic symptoms.

ANAYLSIS

The first step in the analysis was to calculate Pearsonian correlations between the variables.[2] Examination of the correlation matrix provided a tentative answer to the two questions. With respect to the first—whether or not opinions regarding mental illness are related to formal education—the results are somewhat ambiguous. A correlation of .12 is statistically significant at the .01 probability level. Only six of the 16 opinion items are correlated with education at this magnitude or greater (variables 1, 2, 5, 8, 9 and 13). The average of the 16 coefficients is only .10, and the highest correlation is but .20 (for variable 8—persons with more education believe parents' attitudes toward children affect their later mental health). The data thus suggest that if there is any relationship between opinions regarding the etiology and prevention of mental illness and formal education, it is indeed a weak one.

A more definite statement can be made about the relationship between opinions regarding mental illness and technical knowledge of psychiatric terms. Of the 16 opinion items 12 are significantly associated with extent of technical knowledge as measured by variable 17, the true-false test. Once again, however, the correlations are quite low in magnitude, the highest being .26 (for variable 10—persons with more knowledge felt constant nagging could help cause a mental disorder). Likewise, there are statistically significant though small correlations between opinions and scores on variable 19, the multiple-choice vocabulary test. Thus, there appears to be a stable but quite weak relationship between knowledge of psychiatric terms and attitudes toward the etiology and prevention of mental disorders.

There are, as could be expected, strong correlations between level of formal education and knowledge of technical vocabulary. The correlation between education and score on the true-false vocabulary test is .62; between education and score on the multiple-choice vocabulary test it is .52. Education is also associated with confidence regarding knowledge of technical terms ($r = .49$), but interestingly enough there is only a low correlation between education and recognition of neurotic symp-

[2] The complete matrix is not included in the paper but a copy may be obtained from the authors.

toms.[3] When income is related to the knowledge variables the same relationships occur, although the correlations are somewhat weaker. Thus, knowledge of technical psychiatric terms probably is not only related to education but to the variety of variables that reflects socio-economic status as well.[4]

To amplify these findings further and to see whether or not the variables could be interpreted in terms of a set of general underlying dimensions, a factor analysis was undertaken. The complete centroid method of Thurstone was employed, with factors rotated to orthoganality.[5] Three factors were extracted before the residual matrix showed no significant departure from chance expectations. The total amount of item variance accounted for by the factor analysis is quite small, suggesting that many of the individual items are not reliable and/or there is considerable independence between specific items. Table 2 reports the rotated factor loadings, the column labeled "h^2" being the amount of item variance accounted for by the three factors.

Factor 1 explains 14% of the total variance. It contains high loadings on education (variable 27), income (variable 28) and the two vocabulary tests (variables 17 and 19). There are only a few opinion items that load significantly on this factor (variables 5, 8, 9 and 14). The factor may be thought of as the general and specific knowledge factor.

Factor 2 accounts for 7% of the total

TABLE 2

Rotated factor loadings

VARIABLE	FACTOR			
	1	2	3	h^2
1	.24	.33	.13	.18
2	.28	.23	.10	.14
3	.18	.23	.14	.10
4	.07	.32	.08	.11
5	.15	.53	—.07	.31
6	—.10	.44	.11	.22
7	—.05	.35	.18	.16
8	.22	.40	—.05	.21
9	.18	.42	.11	.22
10	.05	.57	—.11	.34
11	.02	.57	—.16	.35
12	.03	.55	—.10	.31
13	—.02	.42	.12	.19
14	.19	.50	—.16	.31
15	.09	.20	.15	.07
16	.07	.41	—.07	.18
17	.73	.22	—.19	.62
18	.66	.18	—.26	.54
19	.77	.13	—.24	.67
20	.31	.38	—.15	.26
21	.18	.11	—.08	.05
22	.35	.02	.14	.14
23	.06	—.32	.19	.14
24	.01	.05	.07	.01
25	.35	—.15	.13	.16
26	.47	.00	.20	.26
27	.70	.02	—.23	.54
28	.52	—.01	.03	.27
29	.23	.07	.31	.15
30	.29	.02	.20	.12
31	.09	.02	—.17	.04

[3] The low correlation between education and recognition of neurotic symptoms is one of several findings not discussed in detail in this brief research note. Others of interest are the significant correlation between knowledge of psychiatric vocabulary and belief that persons can recover from mental illness, and a stable relationship between knowledge of psychiatric vocabulary and willingness to go to a psychiatrist.

[4] See August B. Hollingshead and Fredrick C. Redlich, *Social Class and Mental Illness: A Community Study* (New York, John Wiley & Sons, 1958).

[5] For a discussion of the statistical procedures, see Benjamin Fruchter, *Introduction to Factor Analysis* (New York, D. Van Nostrand, 1954, chapter 1).

variance and contains high loadings on almost all the items regarding opinions toward mental illness. The factor can be thought of as measuring opinions regarding etiology and prevention of mental illness. It is most notable that with the exception of variable 20—recognition of neurotic symptoms—the knowledge items are not heavily loaded on this factor. Also, neither education nor income are loaded significantly on this factor. Thus, both the Pearsonian correlations and the factor analysis suggest the relative independence of general and specific knowledge about mental health and opinions regarding the etiology and prevention of mental disorders.

The third factor explains but 2% of the total variance. This seems to be the result of a common response pattern among poorly educated rural males. Since it is of small consequence in accounting for variance, however, it will not be discussed further.

DISCUSSION

In brief, the zero-order correlations and the factor analysis indicate that opinions regarding the etiology and prevention of mental illness are only slightly, if at all, related to the level of formal education and that they are only weakly correlated with knowledge of the technical vocabulary of psychiatry.

It would be exceedingly rash to conclude from this one analysis that knowledge has little influence on opinions and attitudes toward mental illness. But these results do call for practitioners associated with mental hygiene and health education programs to be cautious in thinking that giving the people the facts alters their opinions. Since other studies also suggest there is only a slight association between knowledge and opinions, basic research is required into the question of the frames of reference by which persons integrate factual information and personal opinion.[6] Such research would enable the health educator to develop more realistic community mental health programs.

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[6] The problems and issues involved in mental health education are too complex to be considered in detail in this brief research note. Shirley A. Star, in a paper presented at the 1957 meetings of the American Association for Public Opinion Research, noted: "I think, too, the primary reason for the failure (of mental health education) is readily apparent; it is that mental health education has primarily devoted itself to attempting to implant its psychiatrically oriented conclusions into the thinking of people starting from different premises. Now these conclusions I keep referring to are generally called facts; you know, mental health education disseminates the facts about mental illness."

The evidence available with respect to the relationship between knowledge and attitudes, moreover, tends to support our findings, suggesting the urgency for such basic research. For example, Stouffer and his associates as well as others have noted that the attitudes of only a small proportion of individuals is determined by rational analysis of relevant facts. See Samuel A. Stouffer, and others, *The American Soldier* (Princeton, Princeton University Press, 1949, Vol. 1, 465–66).

SALOMON RETTIG, PH.D.
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Status, work satisfaction and variables of work satisfaction of psychiatric social workers

This paper is a report on a portion of a larger project dealing with the status and job satisfaction of mental health workers in both state institutional and non-state institutional job settings.[1] The concern here is with the motivational characteristics of a group of female state hospital social workers, with a focus upon the relation between their status and their work satisfaction. Conceivably, the status of the social worker may be a more important aspect of her work satisfaction than some of the more commonly considered factors, such as pay, regular work hours, preferred type of patient (client), security, etc.

The role of the social worker in relation to the others with whom she works is poorly defined. The psychiatrist, psychologist, social worker and nurse are often supposed to operate as a team, but the responsibilities of the social worker are not clearly delineated and the regulations for her behavior not clearly prescribed. The social worker aspires to a status similar to that of the psychiatrist and psychologist, while generally speaking she has less education and is more often female. For these reasons the social worker, while desiring to compete for equal status, is at a disadvantage in this competition.

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[1] S. Rettig, F. N. Jacobson and B. Pasamanick, *A Comparative Analysis of Status, Factors of Job Satisfaction and Statement of Job Satisfaction of State Institutional and Non-State Institutional Professionals.* Professional Notes No. 16, Psychological Services. Columbus, Ohio Department of Mental Hygiene and Correction, Division of Mental Hygiene.

The social worker also faces the antagonism of some of her clients. She is an intermediary between those to whom she is responsible and the client with whom she is expected to deal. Even though she is supposed to be a negotiating agent, she does not always have authority commensurate with her job.

While the total sample utilized in this study included 578 persons, our concern here is with a group of 28 social workers from three state hospitals and one state school. A group of 40 nurses are also reported on for purposes of comparison. In the original sample there were 80 social workers from various agencies and hospitals. From this group all of the male social workers were eliminated. Also, all those female social workers who did not work in the same state institution as the nurses were not used in this study, so as to match the two groups for sex and place of work. Both groups are considered workers in the area of mental health.

METHOD

The data are based on standardized individual interviews with 578 persons from five different professions and from the lay public. The professions represented were psychiatry, psychology, social work, teaching and nursing. The professionals were selected from six state hospitals and schools, from 27 clinics, agencies, general hospitals, and public schools, and from private practice. In addition, the samples included a group of 40 non-psychiatric physicians in private practice, a group of 28 psychiatric residents, and a group of 59 upper middle and 51 lower middle class lay persons.

During the interviews each person was asked to rate a set of professional specialties, according to their status and prestige, as the general public would rate them. The professional specialties consisted of the professions comprising the sample and 12 additional professions. These individuals were then asked to rate the status they themselves desire to have (aspired status) and the status they expect to receive from their own and other professions. Each individual then rated eight factors of work satisfaction according to their importance and again according to the degree to which each was supplied to them at their work. The factors rated were intellectual stimulation, pay, status and prestige, regular work hours, security, freedom, patient respect, and type of patient. All of the above placements were secured by means of the magnetic board rating technique.[2] Finally, each individual answered a questionnaire pertaining to her work satisfaction and to various objective indices of status such as income, age, sex, etc.[3]

RESULTS

Table 1 shows the mean age, income, total objective status, aspired status, status expected from the general public, and status expected from the profession for the social workers and the nurses. On the whole, the social workers are older and have a higher income and higher objective status;

[2] All variables to be rated are attached to small magnets, which are placed by the social workers on a scale ranging from 0 to 100 and attached to a light steel board. The average test-retest reliability of the technique is .99 using mean judgments and .92 using individual judgments. For detailed information about the technique see Salomon Rettig and others, "The Magnetic Board Rating Technique," *Journal of Psychology*, 45(1958) 201–206, and Claude Bartlett and others, "A Comparison of Six Different Scaling Techniques," *Journal of Social Psychology*, in press.

[3] There were 21 indices of objective status, such as income, age, sex, race, type of advanced degree, etc. For a detailed report see Salomon Rettig and others, "Measurement of the Objective Status of the Professional," unpublished.

TABLE 1

Ratings given indices of status by social workers, as compared to nurses

INDEX	SOCIAL WORKER	NURSE
Age	3.1[1]	2.5•
Income	4.5[1]	3.3•
Objective status	22.8	15.8•
Aspired status	81.1	79.5
Status expected from the general public	59.8	51.4
Status expected from the profession	75.3	70.5•
Work satisfaction	11.6	12.1

• Indicates a significant difference between the means of the two groups, based on a t test.
[1] Age and income in categories.

all of these differences are statistically significant. The social workers aspire to higher status and expect higher status from the general public. The last finding is particularly noteworthy because, as will be shown later, the social workers are accorded a lower status than nurses by the general public. It can also be noted that the work satisfaction of the social worker is lower.

Table 2 shows the importance attached to each of eight factors of work satisfaction and the subjectively felt supply of each for both groups. Although the two groups demonstrate a fairly similar pattern, there are some interesting differences. The difference between the importance attached to security and to patient's respect is statistically significant; security and the respect of their patients are considerably less important to the social worker than they are

TABLE 2

Importance and estimated supply of eight factors of work satisfaction for social workers and nurses

	IMPORTANCE		ESTIMATED SUPPLY	
	Social worker	*Nurse*	*Social worker*	*Nurse*
Intellectual stimulation	89.4	85.8	70.1	73.2
Pay	82.8	79.1	74.3	81.8
Status and prestige	67.9	68.6	72.4	73.3
Regular hours	73.4	71.0	86.4	89.3
Security	73.9	85.0•	84.7	82.0
Freedom	85.9	81.8	78.1	78.1
Patient respect	68.0	78.8•	86.6	84.0
Type of patient	64.1	67.6	72.4	73.9

• Indicates a significant difference between the means of the two groups, based on a t test.

TABLE 3

Correlations between work satisfaction and the sufficiency (supply minus importance) of work satisfaction factors and expected and aspired statuses, among social workers and nurses

SUFFICIENCY OF	SOCIAL WORKER	NURSE
Intellectual stimulation	.32	.26
Pay	.36	.26
Status and prestige	.58*	.23
Regular hours	—.15	—.05
Security	—.19	.33*
Freedom	.61*	.68*
Patient respect	—.07	.03
Type of patient	.37	.16
Status expected from the general public	.13	—.31*
Status expected from the profession	—.22	.15
Aspired status	—.02	—.24

* Indicates a significant correlation.

to the nurse. Also, the subjectively felt supply of pay is lower for the social worker, even though they have a higher income. Both groups attach highest importance to intellectual stimulation, and least importance to preferred type of patient.

Table 3 presents the Pearsonian correlation coefficients between work satisfaction and (a) aspired status, (b) status expected from the general public and from their own profession, and (c) the sufficiency of each of the factors of work satisfaction. The sufficiency of a factor was obtained by taking the difference between the rated importance and the rated supply for each factor for each person. The most striking difference in the pattern of correlation is that, as predicted, the status of the social worker is a crucial determinant of her work satisfaction, while to the nurse security is much more crucial. The sufficiency of freedom is very important for both groups. The relationships between aspired or expected status and work satisfaction are not significant. The highest correlations for the social worker are between work satisfaction and the sufficiency of status and prestige, and work satisfaction and freedom. For the nurses the highest correlations are between work satisfaction and freedom and work satisfaction and security. The aspired status and the status expected from the general public bear no significant relationship to the work satisfaction of the social worker. However, the status the nurse expects from the general public bears a significant, but inverse, relationship to her work satisfaction. That is, the more status the nurse expects to receive from the general public, the lower her work satisfaction.

Table 4 shows that the lay public (composed of an upper middle class and a lower middle class sample) as well as the profes-

TABLE 4

Status ascribed to institutional social workers and nurses, by an upper class sample, a lower class sample and the total professional sample [1]

	SOCIAL WORKER	NURSE
Lower class (N = 51)	35.4	40.0
Upper class (N = 59)	39.3	52.2*
Professional (N = 428)	43.8	46.6*

[1] Excludes ratings of own professional specialty.

* Indicates a significant difference between the means of the two groups, based on a t test.

sional sample accords significantly higher status to nurses than to social workers. This finding is consistant for most samples studied.

DISCUSSION

Before entering upon a discussion of the implications of the foregoing findings, it might be advisable to indicate the limitations of what generalizations can be drawn from the sample included in this survey. It should be noted first that while the qualifying phrase "psychiatric" is frequently omitted, the study was confined wholly to psychiatric social workers and the conclusions should be restricted to this group. Although the group reported upon came from four state institutions, analysis of the data indicate that this subsample does not differ significantly from the remainder of the institutional psychiatric social workers. This particular report was confined to a portion of the institutional social workers in order to eliminate the variable of place of work which we had previously found to be of importance.

Despite the finding of some differences between institutional and non-institutional psychiatric social workers, these two groups were much more alike both in self-perception and in the attitudes towards them by other mental health professionals than either social work group was similar to any other professional group under study. It would therefore not be straying too far from the data to state that the findings arrived at would probably be applicable to the cohort of psychiatric social workers in Ohio. We have no data concerning the comparability of Ohio psychiatric social workers to those in the rest of the United States. They probably are not too dissimilar. It is our impression that fairly similar attitudes and perceptions exist throughout the country.

With these limitations in mind then, the social workers, in comparison to the nurses, are older and have a higher income and higher objective status in general. They expect higher status from the various reference groups, but actually receive less. The work satisfaction of the social workers falls below that of the nurses and is affected most greatly by the sufficiency of freedom and status. There is a tendency for the relationship between the status expected from the general public and work satisfaction to be positive for the social workers, while for the nurses it is inverse.

The most striking differences in the motivational pattern between the two groups are in the emphasis on status by

social workers and the emphasis on security by the nurses. Social workers aspire to and believe they have high status but in actuality have low status in the eye of the general public as well as in the opinion of other professional persons. One might say, in summary, that the social workers have a strong status orientation: their status is of crucial significance to them.

The low status accorded the social workers is extremely interesting since they have higher education and greater income than the nurses. In accounting for the low status of the social worker, a number of factors have to be taken into consideration. One possible interpretation of the low status accorded the social worker is that she becomes a scapegoat because of her unique position. It is the social worker who stands between the clients, relatives and community on the one hand and staffs and boards on the other. Since the social worker is the immediate and weak link in a chain of often unwelcome communication it is inevitable that the public (and the profession) she faces will direct their resentment and derogation at her. Another possibility is that the lay public associates social work with welfare activities, which may be a factor that detracts from professional status.

The criticism by professional persons may involve the training and job functioning of the social worker. "Because of the training she has received in most centers, and the incomplete comprehension by all members of the team of the nature and management of psychologic disorder, the social worker has become a psychiatrist in miniature. She has almost entirely cast aside what is, and should be, the most important aspect in her care of the patient: that is, her role as liaison between patient and society. The hard, down-to-earth task of dealing with the environmental factors, of reintegrating the patient into his community, his work, and his family, which is without doubt the single most important job in psychiatric management, has frequently been almost completely neglected in favor of some shibboleth like improving interpersonal relations or another almost as meaningless. It is not the fault of the social work profession, because it has a long and honorable tradition of doing well a hard, thankless job with excellent insight and fearless honesty. It is the concept of mental disease as an intrapsychic conflict, existing in a vaccum, which has seduced the social workers to their present status. If they do not soon take stock of their function, I greatly fear that they will find their profession will have crumbled to dust, with the psychiatrists taking their own medical histories, as they should, with trained psychotherapists doing the individual therapy, and public health nurses doing the social work as they have done so well in other medical fields." [4]

Because of the above reasons the status of the social worker is low, both in the eyes of the general public as well as in the opinion of other professionals. High demand for recognition coupled with a low supply makes for dissatisfaction, low morale and strained professional interrelationships. A rise in the status of the social worker can come about only by improved training, stronger professional organization and, perhaps most of all, better defined job responsibilities in those areas in which the social worker has undisputed authority and in which she can make her greatest contribution without having to compete for status with other professions.

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[4] B. Pasamanick, "The Scope and Limitations of Psychiatry" in *Basic Problems in Psychiatry,* edited by J. Wortis. New York, Grune and Stratton, 1953, 43–44.

SUMMARY AND CONCLUSION

The purpose of this study is to report the findings on the status and work satisfaction of a group of state-employed psychiatric social workers from four state institutions. The report derives from a larger study of the status and work satisfaction of state and non-state employed professionals in Ohio. It was conjectured that the status of the social worker is of crucial importance to her work satisfaction.

The social workers are compared to a group of nurses. Both groups are females engaged in mental hygiene work, and they come from the same state institutions.

The findings indicate that the social workers aspire to and believe they have higher status than is accorded them by samples of various professional and lay persons. While the income, education and total objective status of the social workers is higher than that of the nurses, the status accorded them is consistently lower. There is a significant relationship between the sufficiency of status and work satisfaction for the social workers, but not for the nurses.

In accounting for the low status of the social worker, reference was made to the ill-defined lines of authority and the ambiguous role played by the social worker. Also mentioned were the resentment and the derogation by the general public because of scapegoating by the lay public and because of associating social work with welfare activities.

It is suggested that an increase in the status of the psychiatric social worker can be accomplished by improved training, stronger professional associations and clearer role assignments.

BYRON G. WALES

Rewards of illness

Observations on institutionalization by a former neuropsychiatric patient

How and why does an individual become dependent upon the decisions and resources of the staff in a neuropsychiatric institution? Could it be that too much kindness and loving care fosters dependency upon a protective environment, undermining an individual's initiative and resourcefulness, independence and potentialities, so that his proclivities toward becoming a useful member of society are rendered impotent? Assuming that this is true, is this a desirable state of affairs?

It is a recognized fact that when an individual has been in a neuropsychiatric institution for a long period of time, and has become so well-adjusted to the hospital milieu that he knows or cares to know of no other way of life, he is said to have become "institutionalized." The essence of the pattern involved occurs, if one lives long enough, with most human beings. Basically it is a degenerative process. It is resignation and apathy toward the conditions of their lives. It is surrender to the demands of a dispassionate "fate." Still, when this pattern is enacted in a man's youth, or in his prime, it is a tragic and premature epilogue to a life.

Self-induced failure, as a mechanism of defense, is a well-known psychiatric syndrome. It "represents a protective device which the ego uses to shield the environment and thus himself from the impact of certain instinctual drives" (1). In providing prolonged and continued asylum to such individuals the hospital is apt to defeat its avowed purpose. It can easily perpetuate the individual's difficulties and tend to strengthen his dependency upon other people's decisions and resources, leading to "institutionalization."

Sooner or later many chronic mental

Mr. Wales, a resident of East Providence, R.I., has experienced many years of intermittent hospitalization in neuropsychiatric institutions.

patients in good contact are accused of or censured for, either by others or by their own conscience, being too dependent upon the protective environment of the hospital. When others speak of this dependency it is almost always implied that these attitudes are the patient's fault, that the patient really enjoys being taken care of by others, and that such attitudes are unnecessary and unnatural. Perhaps in the final analysis this is true. But it has been the author's experience that most professional personnel, like the majority of people in the community, seem loathe to recognize the possibility that this dependency could be fostered and perpetuated in the artificial and highly structured social milieu of the hospital. Wrote Adolf Meyer in 1932: "If there is any one basic feature of modern progress in the study of psychoses, it lies in the recognition that psychoses cannot be understood and evaluated merely by observation of patients as admitted to the hospital and by a description of the full-fledged disorder, but that it is necessary to give full consideration to the broader and antecedent situations and origins, as well as the resulting developments, including the inferences worth drawing from the experience with the treatment of the conditions and management of the problem from the preventive aspect" (2).

In stressing real or fancied attitudes of dependency, little if any recognition appears to be given to the factors which tend to create passivity and reliance upon other people's decisions and resources. It should be fairly obvious that an institution, such as a neuropsychiatric hospital, is inherently notorious for inhibiting an individual's liberty and substituting "security" for "freedom." Although a patient may be told that "everything is up to you," the mere fact that medical care, food, lodging and entertainment are provided automatically impresses the patient otherwise. He is told when to rise and when to go to bed, when to eat, when to work, when to be entertained. He is given, or not given, ground privileges and passes to leave the confines of the hospital at the discretion of authority figures whose power is, to all intents and purposes, absolute. And he is in most instances powerless over, and even unaware of, the criteria which influence these decisions.

A priori, he is a mental patient! And his daily interpersonal relationships with other patients, doctors, nurses, aides and ancillary personnel are fraught with the specter of mental illness. As it is usually in the nature of his illness that ego strength is diminished, surroundings replete with locked doors, rattling keys, refractory wards and men in white coats do little toward mitigating this situation. For most administrative problems appear to be intertwined with subtle force and restrictive measures. Also, when these factors are present to an excessive degree the mental patient is dealing primarily with a custodial rather than a therapeutic culture. And the degree of custodial emphasis proportionately influences dependent feelings over a period of time.

"A study of the hour-by-hour life of the patients in the average mental hospital often gives a most unhappy picture," Hyde and Solomon point out. "Not infrequently it shows a combination of idleness, inactivity, boredom and regimented uselessness. Such a situation is certainly not conducive to recovery and can create a 'prison psychosis.' Somewhere in the treatment of the mentally ill is a place for providing those opportunities for choice, expression and creativity that are so prized in democratic society" (3).

How does a condition such as dependency and institutionalization evolve? It

is a common feeling among patients that they have been unjustly deprived of their freedom. And in most instances, in one sense of the word, this is perfectly true. For very few individuals ever come to a mental hospital voluntarily. When someone becomes mentally ill, usually some other individual or agency has to step in and see to it that he receives proper treatment and care. Thus the mentally ill individual finds himself, in many instances, committed to an institution without having very much to say about what is happening to him. Naturally these steps have been taken for the mentally ill person's protection or for the protection of society. But this does not alter the fact that in most places designed for the care and treatment of the mentally ill in our culture there are a great many locked doors—which heightens his sense of restriction and detention.

Because the mental patient is involved with a difficulty labeled "illness," almost any steps taken to mitigate his problems are considered justifiable. One does not usually delve deeply enough into the issues concerned to draw parallels. One is apt to forget the lessons of history regarding tyranny and injustice. It is not easy to bear in mind that the physician and other members of the staff in our mental institutions have a great deal of power in their relations with the committed patient. This is not to be construed as a statement that tyranny and injustice exist. But it is an attempt to point out that in any environment where there is dependency upon locks and keys to control the majority of its population tyranny and injustice can flourish. At least this type of behavior can flourish far more easily than it could in an environment where physical restraints were absent. And tyranny and injustice can create dependency.

The acutely ill mental patient can, to some extent, counteract apathy and resignation in regard to his hospitalization by building up feelings of bitterness, resentment and even hate regarding actual or imagined oppression. In most cases, though, it is otherwise with the chronic mental patient. Violent emotional responses and intellectual discord rooted in the sometimes faulty perception and evaluation of daily realities are eventually replaced by a gradual relinquishment of inward incentive, initiative and resourcefulness. The colors, the forms and weathers of surroundings that seldom if ever change close in and weigh down the spirit until there is apparently nothing to do from the patient's point of view but retreat inwardly. A repressive atmosphere of barren monotony dulls the senses until emotional spontaneity becomes atrophied and memories and dreams occupy the patient's mental life. Having, in the course of time, become conditioned and accustomed to this way of life, any sort of a change in routine becomes a painful experience. The patient has become dependent.

"In the hospital management of psychiatric illnesses, especially those of a more chronic nature, many patients improve to the point of a 'good hospital adjustment,' but fail repeatedly in attempts to return to community living. This raises the question whether hospital treatment programs contribute to the perpetuation of mental illness," Sewall writes (4). Usually the staff of the mental hospital does set up the patient's goals and then therapeutically coerces the patient to strive toward these goals. Naturally, if the end result doesn't materialize the way the staff had planned, the patient is apt to be censured or punished, and the fact that social drill, or an enforced conditioning process, can be far less effective than mimesis is ignored.

It must be remembered that these re-

marks are not intended as an indictment, but as observations regarding one deplorable, and perhaps unavoidable, facet of institutional management. Moreover, they are a plea for recognition of the fact that daily, all over our land, there are a certain number of men and women who are sitting unhappily and unproductively on hospital wards designed for those who are actually acutely or chronically ill. Men and women who, if given the proper understanding and encouragement, hopefully might order and sustain their own lives in the community. As one authority has said: "The hospital's functioning should be geared to produce a situation of flexibility where the problem of first treating the sick patient and then aiding him to make the transition from the hospital to the community is of prime consideration" (5).

The major part of the treatment program for the chronic mental patient, in most of our mental hospitals, appears to consist of prolonged milieu therapy. And milieu therapy in an institutional setting, in some cases, is woefully lacking in benign opportunities for individual growth. Milieu therapy appears to be aimed at resolving those facets of a patient's illness which is directly related to and affects the prevailing mores and customs of society. In short, the rights of society appear to be considered of more importance than the rights of the individual. It is not within the scope of this paper to delve into the merits of the various aspects of the question as to which is the more important. But it is assumed in this instance that as a hospital, according to most dictionaries, is "a place in which the sick and injured are cared for," the sick or injured individual is the more immediate concern.

In some respects, of course, all of us are dependent upon one another. But when an individual becomes dependent upon others to such a degree that he is unable to take care of his own needs and is unable to function adequately in the extramural community, neither the individual nor society benefits. Professional personnel have been known to comment that the neuropsychiatric patient lacks sufficient motivation for displaying healthy attitudes. Still, as Patterson pointed out, "apparently mental patients are much like the rest of us and will respond to attention—with improved performance" (6).

Mr. X, a geriatric patient, was a competent oral surgeon and a minor political figure in a southern community. He is married and has two grown children who are financially well off. He himself is comparatively well-to-do. For a number of years he has been hospitalized in a state hospital for mental diseases in New England. Although he is a World War I veteran with a service-connected disability, he prefers to stay where he is rather than go to a Veterans Administration hospital. He is an amiable gentleman in his early sixties possessing an alert intelligence. In the hospital he enjoys many privileges denied and even unknown to the average patient. His principal complaint is that he has a heart condition, although he will admit when pressed that the doctors have never been able to find anything organically wrong.

Here in the eyes of the layman is a highly educated gentleman with a vast background of experience, potentially a useful member of society, who is spending his declining years unwanted and to all intents and purposes useless to himself and others.

Unfortunately psychiatry is still in its infancy. For many, mental illness is still a fearful thing. Also there is a stigma attached to it. Nevertheless, the oft-repeated

contention that long periods of confinement is a salubrious experience makes a mockery of truth.

Mr. Y, plagued by what appears to be a severe anxiety neurosis to the layman, was a professional photographer in his early twenties. While on pass some months ago he became intoxicated and fell asleep in a restaurant. Picked up by the police and charged with being drunk and disorderly he was brought into court where he was placed on probation. Upon his return to the hospital he was removed from a fully privileged ward and placed on a refractory ward where he spent several months in the company of very regressed psychotic patients. Upon regaining his status as a privileged patient residing on an open ward, he was given frequent passes in his own custody. At the same time the staff, not too diplomatically, impressed upon him that if he got into the least bit of trouble he would be summarily transferred to a correctional institution for an indefinite period of time. After starting out on a week-end pass he became apprehensive and hurriedly returned to the security of the hospital, vowing to forego passes in the future.

In an editorial a few years ago the *Lancet* noted that "There are two historical reasons for the constraint of the mentally sick (who of all people are least able to tolerate it): first, the public demand for protection from something fearful and unintelligible, and secondly, the belief that self-discipline could be instilled by force" (7).

Mr. Z was hospitalized for a psychoneurotic condition complicated by a mild addiction to alcohol. A competent worker in his middle forties, he was soon satisfactorily fulfilling the duties connected with his work assignment in the dietary department of the state hospital where he had been committed. Transferred to a Veterans Administration hospital for further treatment, he became despondent and began brooding about the loss of his freedom. He then commenced drinking heavily while on pass. This soon resulted in a temporary loss of privileges, which added to his bitterness and resentment. Upon regaining his former status at the hospital he soon repeated the episode.

This same pattern, with variations, was continued during approximately three years of hospitalization. Mr. Z halfheartedly attempted suicide on two occasions while he was inebriated during this period of confinement. Transferred to another Veterans Administration hospital closer to his home he continued to display frequent gestures of rebellion. There were numerous elopements and two suicidal attempts plus frequent alcoholic bouts within the confines of the hospital during nearly six years of continuous hospitalization. Within hours after he had been given a maximum hospital benefits discharge he was seeking readmittance to the hospital. This request was denied. When heard from last he was again in a state hospital, primarily for alcoholism.

Upon meeting Mr. X, Mr. Y and Mr. Z one would not be prone to think of them as mentally ill. Even after talking with them and observing them over long periods of time one would be hard put to discover any evidence of psychotic or discernible abnormal behavior as understood by the average individual. None of them was assaultive, destructive or hallucinating in his daily behavior. They were competent conscientious workers who were liked and respected by others. None of them used an abnormal amount of obscene language, none of them was particularly irritable, nor did they display an anergic attitude toward

their daily activities. Their movements were not manneristic and they were not deluded in any particularly bizarre fashion. And certainly none of them was seclusive.

Still, all of them had been hospitalized for long periods of time. They had, like all chronic patients, been uncompromisingly conditioned to the passive acceptance of a loss of physical mobility. Sooner or later, circumstances had forced them to adjust to the fact that a great deal of their time and energy must be spent in coping with confinement or in following a routine of unchanging rigidity. This, as with most patients, conflicted with the normal daily pattern of living which they had enjoyed before they became ill. This combination of circumstances—the fact that like most mentally ill individuals they were, except for the doctor, not in the hospital willingly, and once in the hospital they had been confined on closed wards—accounted for much bitterness and resentment regarding their hospital experience. And propaganda aimed toward the disavowal of those circumstances could serve no purpose other than to perpetuate the problem—which, in its essence, was one of strengthening, not undermining, the therapeutic program.

More than a hundred years ago Thomas Carlyle wrote that "The great law of culture is: Let each become all that he was created capable of being; expand, if possible, to his full growth; resisting all impediments, casting off all foreign, especially all noxious adhesions; and show himself at length in his own shape and stature, be these what they may" (8).

In practically all mental and emotional disorders, the ego, or the individual's conscious idea and understanding of himself and his relationships to the world in which he lives, is adversely affected. And a wounded, faltering ego is in no position to deal with life's everyday problems, least of all confinement and regimentation. Without our self-respect or our self-esteem none of us is of much use to ourselves or to others. Unwarranted restrictive measures are never conducive to growth.

Reliance upon the hospital for support at a time when an individual is mentally or physically unable to provide for himself is understandable. But it is illogical for hospital management to maneuver or allow itself to be maneuvered into a position in which it accepts responsibility for the welfare of an individual who does not need and does not consciously want this care and treatment. This is doing a disservice, both to the patient and to society. Making a "good hospital adjustment" implies to the layman that, if the institution where an individual is hospitalized is therapeutically oriented, he should be considered well and ready for discharge. Unfortunately, where custodial care in a neuropsychiatric institution is the principal motivating factor, discharge of a patient when he has reached the peak of his capabilities and capacities for health seldom occurs. Thus a benign equinox in the patient's growth passes unheeded and his original emotional difficulties are eventually intensified. "The factors that influence the development and course of mental illness have been classified by one authority (Dr. Nolan D. C. Lewis) as predisposing, precipitating and perpetuating. Little can be done in adult life to modify predisposing factors. Precipitating factors are ordinarily of brief duration. The major problem in the treatment of emotional disorders, therefore, is dealing with those factors that influence the course of mental illness—the perpetuating factors" (9).

Throughout the span of recorded history sin, in the minds of certain individuals, has somehow been associated with illness—as though man alone were entirely to blame

for his misfortunes. Over the course of the past few centuries, as medical men have gained knowledge and understanding, man's physical infirmities have, for the most part, come to be accepted with tolerance. Man cannot be expected to control invisible bacteria all of the time. This evidently is not so, though, with mental illness, even though long-forgotten experiences are thought to be partially responsible for the mental patient's confused, inadequate responses to today's stiumli. If it were, we would not have so many locked doors in our mental institutions. Mental illness would be strictly a medical problem, not a sociological problem also!

It would be superfluous to dwell here on the fact that mental illness in America has become a staggering problem. Conceivably, one day, any deviation from the mores and customs of the majority, by an individual, could lead to his being classed as mentally ill, thereby making him eligible for hospitalization. This is one of the reasons why it is felt that far too little attention is paid by professional personnel to those individuals confined in mental institutions who are not, medically speaking, psychotic. And who, being dangerous neither to themselves nor to society at the time, do not constitute a medical problem requiring hospitalization.

Actually, of course, this is another facet of that larger problem known as "institutionalization."

Like any efficient business organization, the management of a hospital for mental diseases is consciously interested in disseminating effective propaganda concerning the patient's hospital experience, to the patients themselves, to relatives and to the public at large. As with all propaganda, much that is said is directed toward allaying doubts and overcoming what might be termed resistance regarding the methods of treatment and the goals of hospitalization. Little is heard, though, about the patient's real thoughts and feelings concerning hospitalization and the loss of his freedom. And time after time one sees men and women who have regained their health still in the institution.

It is like hospitalizing a man with a broken leg and then keeping him in the hospital for months and even years after the leg has healed—rationalizing the situation many times by saying that if the patient were discharged he or she might go right out and break the leg all over again. Ludicrous as that may sound, there would be many tragic facets to such a situation. Innumerable new problems would be created having nothing to do with the original broken leg. Foremost among them would be the problem of dependency as it is related to "institutionalization." Bearing in mind that this is greatly simplifying an idea of dependency as an iatrogenic entity, and that generalizations are dangerous, one may attempt to visualize the various implications of such a situation.

We generally equate normality and the average individual with one who is successfully ordering and sustaining his or her life in the extramural community—an individual who is capable of, and in a position to pursue, life, liberty and happiness in accord with the demands of his constitutional proclivities. At the onset and during the course of an illness many of these things, which have been utilized and enjoyed heretofore as a matter of course, are nullified. This is to be expected, and little or nothing can be done to alleviate matters at that time. But we should not lose sight of our perception and understanding of "freedom," even though it is different with each of us.

What are the rewards intrinsic in the institutional structure? What are the re-

wards of illness? Primarily, of course, as has already been pointed out, the patient has no concern about where his next meal is coming from, where he is going to sleep or where he is going to find shelter from the elements. All of these things are taken care of for him by powerful authority figures who will brook little or no criticism in most instances. Many times the patient feels that he must inhibit any criticism of the staff or of the organization of the hospital, lest he be transferred to a refractory ward.

The chronic mental patient can usually make no decisions of his own except in the most trifling matters. True, ground privileges for good behavior and the occasional pass home (usually in someone else's custody) are matters that, on the surface, ultimately appear to depend upon the patient. But for the long-term patient who has had months or even years of hospitalization behind him the incentive and inclination to leave the refuge of the ward or of the hospital has all but vanished. He has usually tried too many times to surmount the barriers that separate him from the extramural community. Perhaps friends or family are no longer waiting for him. Or perhaps their philosophies are so imbued with the fact that he is considered a chronic case that he no longer has the desire to make an attempt to meet them on an adult basis of equality. And perhaps he has been made to feel that he is somehow different and has finally come to prefer the society of his own kind—other mental patients.

Abnormality, for this type of patient, has become normality over a period of time. "The statistically normal mind can be regarded only as a mind which has responded in the usual way to the molding and deforming influences of its environment—that is, to human standards of discipline, taste and morality. If it is to be looked upon as typically healthy also, the current human standards of whose influence it is a product must necessarily be accepted as qualified to call forth the best in the developing mind they mould" (10).

To function properly, both physiologically and psychologically, each of us must possess some measure of freedom. Applied to the mental patient this might be termed physical and mental mobility. The artificial barriers so prevalent in the institutional environment must therefore obviously be inherently antitherapeutic in their effect upon the patient. Even the most regressed patients perceive this and express their longing and hunger for freedom, in acts of aggression and in apathetic behavior, in an effort to solve the problem. Propaganda to the effect that all behavior of this type is entirely dependent upon inward factors and the course of the patient's illness thus can be a distortion of the truth. Conversely, elopements and other management problems cannot always be explained on a strictly medical basis. It is not necessarily a symptom of mental illness to think it expedient to abandon or seek escape from an unbearable position.

For most of us freedom means being at liberty to make our own decisions. Simple decisions like where and when and what to eat. To be able to work, and to play, and to rest, in accord with the demands of our natures. To be able to choose and pursue, unhampered by another man's moral judgments and autocratic controls, those avenues of expression most in keeping with our individuality. To be in a position to expend our energies in harmony with the rhythm of growth unique with each of us alone. To be free to acquire the wisdom and knowledge most in keeping with our inclinations and tastes—Regardless of the social level of this pursuit

of happiness. To be in a position to combat the coercion and ill-considered advice and opinions of others. And to be free to shun the well-intentioned tyrannies thoughtlessly imposed upon us by others, which tend to make us hypocrites. When we are abundantly in possession of these intangibles most of us function fairly adequately—if we have our health also—both in our relations with ourselves and in our relations with our fellows.

The mental patient has lost the ability and the opportunity in many instances to enjoy most of these things.

It is a paradox that when a long-term patient is released from a mental hospital the reaction from the accumulated emotional tension and intellectual conflict prevalent in an environment where, to a greater or lesser extent one is dependent upon the decisions and resources of others, may for some time lead to more rather than less difficulty in the man's readjustment to the accepted normality of society at large. Hospitalization may have eradicated the overt symptoms of his illness at the expense of his character, personality and individuality as a human being.

SUMMARY

The author has attempted to point out some of the malignant facets of long-term hospitalization for the non-psychotic neuropsychiatric patient. Primarily a concept of iatrogenic dependency has been stressed. The author has attempted also to point out that months or years of a man's life spent segregated from the extramural community, with little or no contact with the prevailing mores and customs, produce changes in the man, and indirectly in his family and friends, from which recovery is neither immediate nor easy.

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ANNE S. EVANS, M.S.
DEXTER M. BULLARD, JR., M.D.

The family as a potential resource in the rehabilitation of the chronic schizophrenic patient

An important focus of the recent interest in the hospitalized mentally ill is the patient's relation to his family and community. For the chronic schizophrenic patient, tranquilizing drugs have brought renewed hope of increased contact with the outside world. This same goal has been the aim of the social therapies for many years. These include occupational and recreational therapies, work and rehabilitation programs, and extensive contact with hospital personnel.

Mrs. Evans and Dr. Bullard are on the staff of the Massachusetts Mental Health Center in Boston. The investigation reported here is part of an ongoing research grant supported by the National Institute of Mental Health.

[1] Bullard, Dexter M., Jr., M.D. "The Relative Value of Ataraxic Drugs and Social Therapies in the Treatment of Chronic Schizophrenia" (submitted for publication).

An investigation of the relative value of drug and social therapies in the treatment of chronic schizophrenia was undertaken at the Massachusetts Mental Health Center. A group of chronic schizophrenic patients was brought to the center and treated with tranquilizing drugs and social therapies for six months with the aim of rehabilitation and discharge.[1] During this study the improvement in many patients which seemed to warrant discharge did not always result in discharge. The success or failure of plans for discharge was often found to be dependent on the relationship between the patient and his family. This led to a study of the factors that influence this relationship.

The present report will describe the relationship between the chronic schizophrenic patient and his family. It will present a picture of the patient's behavior on the wards

of the Massachusetts Mental Health Center, of his behavior with his family, his social and occupational skills and his financial resources. The family will be examined in detail, including the home situation, the extent of the family's interaction with the patient and the family resources available to the patient.

CRITERIA OF SELECTION

The subjects were 24 inpatients of the Metropolitan State Hospital, Waltham, Mass. All had been continuously hospitalized at least 5 years with a diagnosis of schizophrenia.[2] There were no diagnoses of organic deterioration or mental deficiency. All patients were between the ages of 25 and 50; their average age was 38 years and their median age was 37 years. The average length of hospitalization was 11 years and the median length of hospitalization was 10 years. There were 14 women and 10 men in the group. Selection of these patients was made by random sample from the 46 patients at the Metropolitan State Hospital fulfilling the criteria of selection.

The families in the study included parents and siblings (families of orientation), spouses and children (families of procreation), and collateral relatives of these patients.

METHOD

The patients were transferred to the Massachusetts Mental Health Center beginning in November 1956 at the rate of one per week. They remained for a 6-month period unless discharged earlier. The patients remaining at the end of 6 months returned to the Metropolitan State Hospital. During the 6-month period at the Massachusetts Mental Health Center they were treated with a combination of tranquilizing drugs (chlorpromazine and reserpine) and with intensive social therapies. These social therapies included psychotherapy, social casework therapy, contact with students of various disciplines, occupational therapy and a rehabilitation program. The rehabilitation program covered work opportunities inside and outside the hospital and training in job skills.

Material for this report on the patients and their families was gathered following the patients' transfer to the Massachusetts Mental Health Center. The patients were interviewed by a psychiatrist and observed by a social psychologist to determine their psychiatric and social disability. A history of the patient's illness was obtained from the Metropolitan State Hospital record. The patient's individual psychiatrist reported his evaluation of the patient's progress during the 6-month period. The patient's job and social activities at the Massachusetts Mental Health Center were recorded at the time of the study.

The families were interviewed by psychiatric social workers of the center's inpatient adult unit. Because the hospital records were inadequate, the research staff obtained information from social service interviews with the social worker about the number of living family members, the number of family visits prior to transfer from the Metropolitan State Hospital, the family's perception of the patient's illness, and the family's attitude toward the patient's release. At the time of admission to the

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2 The specific diagnoses by the hospital staff were as follows:

Schizophrenic reaction, paranoid type	6
Schizophrenic reaction, catatonic type	5
Schizophrenic reaction, simple type	2
Schizophrenic reaction, hebephrenic type	1
Schizophrenic reaction, chronic undifferentiated type	10
Total	24

Massachusetts Mental Health Center, information was also gathered from the family concerning the patient's and family's resources. Supplementary data concerning the financial resources of the patient and family were obtained from the Massachusetts Department of Mental Health.

LIMITATIONS OF THE STUDY

The authors are aware of the small number of cases and many descriptive categories; therefore, the data will deal with trends rather than statistically significant information. We have purposely limited this report to a description of the family as a potential resource and have omitted any data about the family's role at discharge. This will be discussed in a later report.

OBSERVATIONS OF THE PATIENTS

As Richard York points out,[3] the chronic schizophrenic patients "have settled down to a minimum level of activity and social interaction . . . they have slipped into an isolated, anonymous, apathetic condition." These patients at the Massachusetts Mental Health Center showed many of the characteristics of the long-hospitalized chronically ill patient. In interacting, they were distant, remaining by themselves unless invited to join in a social situation. When approached, most were quiet and reserved, discouraging further contacts. Despite this difficulty in making social contacts, these patients generally took responsibility for themselves. The majority (58%) took care of their personal appearance and clothing adequately. Three-quarters of them lived on open wards, went to the cafeteria for meals and to other parts of the hospital for activities. Over one-third (38%) made some use of privileges to leave the hospital during the day for walks, job-hunting or trips to the drugstore. Two-thirds worked at some daily ward task—sweeping, making beds or waxing floors. One-half of the patients worked regularly at some job in the hospital—in the coffee shop or on the paint crews.

In their relationships with their families this group of patients took little initiative. None were active in phoning, writing or visiting their families, even patients with full privileges. One patient pretended indifference to his family, only to break down and cry when visited by his brother. When they were visited or taken out for weekends by their families, the patients were usually docile and, though pleased, did not themselves take steps to continue the family contact.

The patients' resources reflected the disability of their disease as well as the effects of prolonged hospitalization. None of the 24 patients had any personal income and none had any savings, as might be expected after five years or more of hospitalization. Their job aspirations were limited; few had acquired a trade prior to their illness. Only three of the 24 had held a skilled job. Added to this, none of the patients had held paying jobs during their hospitalization. More than one-third (38) were still in school when they became ill.

Thus, because of the patient's inability to handle his life situation, other resources had to be explored before there could be any change. The primary potential resource available to the patient was his family, and it was to the family that the patient and the hospital looked for assistance.

OBSERVATIONS OF THE FAMILIES

Our interest in the family covers three areas: (1) the family situation, (2) the rela-

[3] Greenblatt, M., R. York and E. Brown, "From Custodial to Therapeutic Patient Care in Mental Hospitals." New York, Russell Sage Foundation 1955, 354.

tionship between the patient and the family, specifically the patient's illness and the family's attitude toward his release, and (3) the family resources available to the patient.

A study of the family situation showed a dearth of family members. This lack extended to the families of orientation (parents and siblings), of procreation (spouses and children) and collateral relatives (aunts, uncles, grandparents).

By the time of transfer to the Massachusetts Mental Health Center, a majority of patients (17) had lost one or both parents. Five patients had no parents at the time of transfer. Three patients had no available living relative. Nineteen patients were not married. Of the five patients who were married, none had spouses to go home to because of legal separation or divorce.

Thus, a member of the family of orientation rather than the spouse was legally responsible for the patient. Despite the absence of parents and spouses, 21 patients had living siblings. This would appear to be a primary resource to the patient. Many siblings, however, lived outside the Metropolitan Boston area.

For example, the family of a 37-year-old divorced man consisted of his aged mother and a younger married brother. Contact with Mr. A's family was limited by his mother's inability to come to the hospital because of her infirmity. His brother lived in Rhode Island.

Noteworthy was the fact that many families remained interested in the patient even after prolonged hospitalization. Twenty-three patients were visited at the previous hospital by their families and two by friends. This is summarized in Table 1.

Prior to transfer, one-half (12) of the patients were visited once a week and an additional five patients were visited once a month. Though the frequency of visits appeared to drop off after the patient had been hospitalized for 13 years, a majority of families continued to visit the eight patients hospitalized more than 13 years.

TABLE 1

Family visits in relation to length of patient's hospitalization and sex

	NUMBER OF PATIENTS VISITED										
Length of hospitalization (years)	*Once a week*		*Once a month*		*Holidays only*		*Never visited*		*Subtotal*		*Total*
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	
5– 8.9	1	3	1	1	0	0	0	0	2	4	6
9–12.9	1	4	1	0	1	0	2	0	5	4	9
13 and over	1	2	1	1	0	0	1	2	3	5	8
Subtotal	3	9	3	2	1	0	3	2	10	13	–
Total	12		5		1		5		23		23*

* In one female case whose length of hospitalization was 17 years, the number of family visits was unknown.
M = Male.
F = Female.

TABLE 2

Family's perception of illness in relation to patient's total hospitalization

LENGTH OF HOSPITALIZATION YEARS	"HOPEFUL"	"HOPELESS" *	TOTAL
5–12.9	11	3	14
13–20.9	4	4	8
Total	15	7	22**

* "Hopeful" means the family felt the patient's chances for recovery were "good" or "fair." "Hopeless" means that the family felt the patient's chances for recovery were poor.
** In 2 cases the family's perception of illness was unknown.

The female patients were visited more often than the male patients. The patients' age did not correlate with visits made by the families.

FAMILY'S PERCEPTION OF ILLNESS

The family expressed a wide range of opinion regarding the patient's illness. This is shown in Table 2. Fifteen families perceived the patient's illness as being curable or they were uncertain about curability. Of the eight families who thought the illness curable, three did not feel that the patient was ill. Samples of families' remarks were: "He doesn't really need hospitalization" and "I don't believe he's really sick—just too timid." The remaining five families were optimistic about discharge as a result of the transfer to the Massachusetts Mental Health Center. "She's been in the hospital a long time. Perhaps now she can get out."

Seven families were uncertain whether the patient's illness was curable or not. One family expressed this in the following: "She's been sick a long time. I hope she gets better but we really don't know what the chances are."

Seven families said that the illness was incurable: "A hopeless situation beyond anyone's control" or "Been in the hospital too long to be cured."

In two cases the family's perception of the patient's illness was not known. The family's perception of illness did not correlate with the patient's age or sex.

The family's attitude regarding the patient's illness did seem to correlate with the length of the patient's hospitalization. Of those families who were "hopeful," eight, or one-half, felt the patient's chance for recovery was "good" and the other families felt the patient's chances were "fair." All of these patients whose families felt that the chances for recovery were "good" had been hospitalized less than 13 years. After 13 years of hospitalization, one-half of the families felt that the patient's chances of recovery were small. This feeling on the part of the family is in accord with studies [4] indicating that the prognosis for patients becomes worse as the length of hospitalization increases. No correlation was found between family visits prior to transfer and the family's perception of illness.

[4] Greenblatt, M., R. Arnot, and H. C. Solomon, *Studies in Lobotomy*. New York, Grune and Stratton, 1950, 181.

TABLE 3

Family's attitude toward patient's release in relation to familial perceptions of patient's illness and sex of patient

PERCEPTIONS OF ILLNESS	ATTITUDES TOWARD PATIENT'S RELEASE						
	For or ambivalent		*Against*		*Subtotal*		
	M	*F*	*M*	*F*	*M*	*F*	*Total*
"Hopeful"	4	8	2	1	6	9	15
"Hopeless"	1	2	2	2	3	4	7
Subtotal	5	10	4	3	9	13	
Total	15		7		22		22*

* In 2 cases the family's attitudes were unknown.

FAMILY ATTITUDES TOWARD RELEASE

Although all of the patients were hospitalized continuously over five years, the families expressed an interesting difference of opinion regarding the patient's release. Eight, or one-third, of the families favored release. Remarks such as "The family can take him," "Everyone wants him home" and "Sister is willing to take him" were made. Seven of the families were uncertain about release. They wanted the patient home but only if he had no outbursts. Eight [5] of the families, or one-third, were against release unless the hospital guaranteed complete cure.

Most families who saw the patient's illness as being curable favored release. One mother felt that her daughter was not mentally ill and was anxious to have her at home. Four of the seven families who considered the patient's illness incurable were opposed to release.

The families of the women patients favored release more often than those of the men, who expressed fear of aggressive acts.

[5] One family's attitude was unknown.

TABLE 4

Family's attitude toward patient's release in relation to family visits

	ATTITUDES TOWARD PATIENT'S RELEASE		
	For or ambivalent	*Against*	*Total*
Once a week	10	2	12
Once a month	3	2	5
Holidays only	1	0	1
Never visited	1	4	5
Total	15	8	23*

* One family's attitude is unknown.

TABLE 5

Attitudes of families who were for or ambivalent regarding patient's release in relation to patient's sex

SEX	EXPECTATIONS OF FAMILY			
	Minimal maintenance *	*Assistance in home* *	*Partial or complete independence* *	*Total*
Male	3	0	2	5
Female	6	4	0	10
Total	9	4	2	15

* Minimal maintenance means that families expected the patient to feed and clothe himself. Assistance in the home means they expected the patient to help in the home—make beds, wash dishes, baby sit, etc. Partial or complete independence means they expected the patient to take over his or her former role —for the male to assume financial independence and for the female to take over the duties in the household.

For example, the father of one 32-year-old man was afraid that he would harm the children in the household.

The family's attitude toward release did not correlate with the patient's age or length of hospitalization.

As Table 4 illustrates, the families who frequently visited the patient were most interested in his discharge. One-half of the families who were against release never came to see the patient.

The families who favored release (15) did not have unrealistic expectations of the patients. A majority of these families required only that the patient be able to maintain himself in the home. Further, no female patients were expected to provide financial assistance.

Once again there was no correlation between the patient's age or length of hospitalization and the family's expectations.

FAMILY'S AVAILABLE RESOURCES

Financial

The families were generally in the extremely low income group. The financial resources were discussed in 23 of 24 families. About two-thirds made less than $3,000 annually. The median income of these families was $2,500 a year, considerably less than the national family median income of $4,971 [6] a year.

Fourteen families stated they would be able to assist the patient; three families were able to assume complete financial responsibility, 11 partial responsibility. Nine families could not give any kind of financial assistance.

Family income came from a wide variety of sources. Seven families were supported by resources outside the family of procreation; three families were not self-sustaining, being assisted by collateral relatives. One family was getting unemployment benefits. One family was supported by aid to dependent children and 2 families received old age assistance.

Living arrangements

Twenty families discussed their living arrangements with the social workers. Despite being in the low-income group, 11 or slightly over one-half of these families stated they could be responsible for living arrangements. Nine felt they had room for the

[6] U.S. Bureau of Census, *Population Series T60*, No. 29, June 1958.

patient at home. Two offered to subsidize apartments if the patient were discharged. Nine stated they could make no provisions for the patient.

Employment

Very few families were able to help with paid employment. Eighteen discussed the possibilities of employment. The members of only one family felt they could help the patient get a job. Seven families told the social workers that they would give the patient unpaid employment in the home. Ten could not make provisions for the patient's employment and felt he or the hospital would have to assume this responsibility.

Recreational activities

We found nothing conclusive about this aspect of the patient's rehabilitation. The question of recreational activities was discussed in only 10 cases. In nine of these cases the family had outside interests in which the patient could join. These groups were either social or religious clubs. Only one family said that they did not belong

TABLE 6

Resources of the family in relation to the family's attitudes toward the patient and toward release

RESOURCES AVAILABLE FOR THE PATIENT	PERCEPTION OF CURABILITY OF PATIENT'S ILLNESS			FAMILY ATTITUDE TOWARD RELEASE		
	"Hopeful"	*"Hopeless"*	*Total*	*For or ambivalent*	*Against*	*Total*
Financial						
Yearly family income:						
$2,000–over	5	5	10	7	4	11
0–1,999	9	2	11	7	4	11
Total	14	7	21	14	8	22
Living Arrangements						
No provisions	5	3	8	5	4	9
Have room at home or could subsidize apartment	9	2	11	10	1	11
Total	14	5	19	15	5	20
Employment						
Cannot make provisions	7	2	9	8	2	10
Family can help patient get a job or can give unpaid work at home	7	1	8	7	1	8
Total	14	3	17	15	3	18

Note: The totals represent the number of families whose resources and attitudes were known at the time of transfer.

to any clubs, but that they did entertain and would include the patient in their plans if at all possible.

As Table 6 shows, the family income was related to the family attitude toward the patient's illness. Families making less than $2,000 per year in most cases felt the patient's illness was curable. Only one-half of the families making over $2,000 per year felt the illness was curable. However, the poorest families (under $2,000 yearly) did not markedly favor release. Living arrangements were also associated with family attitudes. The availability of a room at home for the patient correlated with a belief in curability and an interest in release.

DISCUSSION

The aim of the present report has been to examine the family as a potential resource in the rehabilitation of the chronic schizophrenic patient. Many of these patients have functioned successfully in a custodial hospital environment. This level of functioning might extend to some increased interaction with the community. Yet the nature of the disability prevents these patients from initiating contact with the community. We find that the primary potential community resource available to the patient is his family.

A striking finding of this study is that families continue to visit the patient, even after he has been continuously hospitalized for a minimum of five years. This interest persists despite a lack of or the unavailability of many family members. Apparently one should not underestimate the strength of family ties, even after prolonged separation. The nature of this family bond and to what extent it involves affection, guilt or other feelings need further investigation.

Contrary to our expectations, the patient's age had no bearing on the frequency of the family's visits. One reason for this may be the limited age-range of our sample (25–50 years). The greater interest and optimism of the families of women patients were expressed in more frequent visits. This may be due to the fact that these families did not express fears of aggressive acts. Therefore, because they were less frightened about their sick relative, they were freer to think of the possibility of release. Also, families of female patients may have been more optimistic about release because they thought that the patient could help the family with the housework, baby sitting, etc. This finding that no families expected female patients to provide financial assistance might suggest a different approach in the rehabilitation of these patients. It is possible that their rehabilitation might be oriented more toward the home, and that the rehabilitation of male patients might be oriented more toward a job situation.

Families, however, were limited in the amount of assistance they could offer the patients. The income of these families was very low at the time of transfer. This finding is in accord with Hollingshead and Redlich [7] who have indicated that many chronic schizophrenic patients come from families of substandard income. Many families did not have room for the patient, nor could they help the patient get a job in the community. Again, because of low income nine, or slightly under one-half of the families, did not have extra living arrangements, nor did they have businesses which could incorporate the patient.

The attitudes of the families were related to their income. The lower-income families

[7] Hollingshead, August B. and Frederick C. Redlich, *Social Class and Mental Illness: A Community Study*. New York, Wiley, 1958.

were more optimistic about their relatives' chances for recovery. Possibly these same families might be more tolerant and they might be less sophisticated about mental illness and less self-conscious about amalgamating the chronic patient into their social milieu. These families favored release more often than the higher-income families. This finding might indicate that the family with limited circumstances is not pressured by the hospital to assume more responsibility in the rehabilitation of the patient. The limited expectation of the family in regard to release often appeared to differ from the expectations of the hospital staff, which is inclined to expect more independent behavior from patients considered for discharge.

The realistic limitations of many families of the schizophrenic patients suggest several avenues of assistance. The psychiatric social worker's continuing contact might enable the family to deal more effectively with the problems of chronic schizophrenia. The worker might assist the family in making better use of community resources. There is, however, an increased need for expanding these resources to include further financial aid to the family, increased use of family-care programs,[8] more half-way houses[9] and sheltered workshops. Perhaps even more important is the need for a positive attitude towards the possibilities of increased social effectiveness of the chronic patient by the psychiatric social worker on the hospital staff, by social workers in community agencies and by the community.

SUMMARY

Twenty-four families of chronic schizophrenic patients undergoing treatment with drug and social therapies were studied to determine their potential role in the patient's rehabilitation and discharge.

Many of these families continued to maintain an active interest in the patients. This interest was expressed in continuing visits to the hospital and hope for possible recovery and discharge. Their interest was limited by a significant lack of available family members. The family's contribution to rehabilitation and discharge was complicated by financial insecurity, insufficient room at home for another family member, inability to help the patient find a job and lack of social resources.

The importance of the increased use of the psychiatric social worker as well as additional community resources was emphasized.

ACKNOWLEDGMENTS

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[8] Crutcher, Hester, *Foster Home Care for Mental Patients.* New York, Commonwealth Fund, 1944.

[9] Huseth, Brete, "Half-Way Houses: A Review of Factors Crucial to Their Effective Functioning," excerpted in *Mental Hospitals,* 9:8(1958), 5–9.

HUGH G. WATTS
JOHN M. DAVIS

Attitudes toward psychiatry

It is felt that more mental patients could be helped if the psychiatrists could make their initial contact with the patients earlier in the course of the disease. It is important, therefore, to have a sound understanding of the factors which deter people from seeking psychiatric aid when they are in need of it. The importance of this problem is illustrated by the work of Cole,[1] who found that of 111 persons found to be mentally ill in a random survey of 200 Salt Lake City families, only 13 received psychiatric treatment—in spite of the fact that 61 recognized that they were mentally ill.

For the success of a mental health program, it becomes important to understand the attitudes which people have toward psychiatry and how they contribute to keeping the mentally ill from the psychiatrist. From this knowledge it may become possible to learn how best to alter these attitudes.

The university campus provides a small and convenient community where attitudes toward psychiatry can be studied. The problems of early diagnosis and treatment are of special importance in this situation where stresses are frequent and acute, and the problems are usually more amenable to early psychotherapy provided that the students are willing to accept it. Work by Meyer[2] indicates that the public seems ready to accept guidance and education in the field of mental health. Certainly, it

When this paper was submitted early in 1959, Mr. Watts was a third-year student at Harvard Medical School and Mr. Davis a third-year student at Yale Medical School.

1 Cole, N. J., C. H. H. Branch and P. M. Shaw, Mental Illness—A Survey Assessment of Community Rates, Attitudes and Adjustments," *AMA Archives of Neurology and Psychiatry*, 77(April 1957), 393–98.

2 Meyer, R. C., "Is the Public Ready to Fight Mental Illness?" New Jersey Department of Institutions and Agencies, 1955.

would seem that college students, subjected to psychology courses and reading matter in related fields, would be even more ready to accept mental health programs into their communities. However, we shall present evidence which indicates that among most of the college students we studied such attitudes of acceptance are largely superficial and that further questioning exposes a basic mistrust of phychiatry.

METHOD

This survey was conducted at a private, all-male eastern university. The sample was composed of 150 undergraduates whose names had been chosen at random from the student directory. Of this sample 10 students could not be seen because of schedule conflicts. The remaining 140 students represented approximately 5% of the undergraduate population. These students were subjected to an interview consisting of 15 sections, each in several parts, as an attempt to elucidate:

- Their attitudes toward counseling in college.
- What they knew about existing psychiatric and counseling facilities.
- Their attitudes toward college psychiatrists.
- Where they would take their problems when they had them.
- What types of problems they felt ought to be dealt with by the psychiatrist and by other men who, by their frequent contact with students (faculty, dean, chaplains, etc.), are in a position to help.

These data are excerpted from a larger study of the effectiveness of the mental health program established at this university.

RESULTS

When the students were asked "What is your attitude toward counseling in college?" 22% of them answered "very favorable," 70% answered "favorable," 6% answered "unfavorable" and 2% "very unfavorable." (See Table 1.)

When these same students were asked "When do you think that it is justifiable to seek help?" 30% replied "anytime," 59% answered "as a last resort" and the remaining 11% answered that it "depended on the individual," "depends on the problem," and "for aptitude information only." (See Table 2.)

The undergraduates were asked to list the various people and places where a student could go for counseling. Although most students thought of the faculty and the chaplains, only 20% (27) thought to list the university psychiatrist. This result had been suspected from pilot study work,

TABLE 1

Student responses to the question "What is your attitude toward counseling in college?"

	PER CENT OF STUDENTS	NUMBER OF STUDENTS
Very favorable	22%	31
Favorable	70%	98
Unfavorable	6%	8
Very unfavorable	2%	3
Total	100%	140

TABLE 2

Student responses to the question "When do you think that it is justifiable to seek help?"

	PER CENT OF STUDENTS	NUMBER OF STUDENTS
Any time	30%	42
As a last resort	59%	83
Miscellaneous	11%	15
Total	100%	140

so a question had been added to determine whether this low figure of 20% represented personal feelings about psychiatry or ignorance of the existence of the psychiatrist. The students were asked "Were you aware, before this interview, that there was a university psychiatrist?" Considering the suggestibility of the question, it is surprising to find that only 30% of the respondents answered "Yes." (See Table 3.)

The question was asked of the students "If you had a serious problem, would you hesitate to go to the psychiatrist?" The answer, "Yes, I would hesitate," was given by 56%. (See Table 4.) To "Why?" the answers were fairly evenly distributed among "Would work out own solution," "Don't know anything about this particular psychiatrist," "Don't know anything about psychiatry," "Depends on the problem," "For religious reasons," "Just don't like the idea," "Psychiatry is no good," and a few miscellaneous answers.

The students were asked what they themselves would do if faced with a problem when they found that they could not reach a satisfactory solution on their own. A set of 11 hypothetical situations was given (for example, "You have no incentive to study and are getting seriously behind in your work, but you cannot do anything about it," "You seriously feel that the whole world seems to be against you," "You are considering dropping out because you feel that you are not getting enough out of this university," "You feel that you are being pushed or are drifting into a marriage that you are not sure you want.").

With the exception of two very specific questions about difficulties with inadequate reading ability and about the choice of a major field of study, on each of the remaining nine questions an average of 14% of the respondents said they would "do nothing."

On the problems that would be considered to be in the realm of the psychiatrist, only 11% (15) said that they would go and

TABLE 3

Student responses to the question "Were you aware, before this interview, that there was a university psychiatrist?"

	PER CENT OF STUDENTS	NUMBER OF STUDENTS
Yes	30%	42
No	70%	98
Total	100%	140

TABLE 4

Student responses to the question "If you had a serious problem, would you hesitate to go to the psychiatrist?"

	PER CENT OF STUDENTS	NUMBER OF STUDENTS
Yes	56%	78
No	44%	62
Total	100%	140

see him. On these problems 13% (18) said that they would talk it over with their roommates or fellow undergraduates.

To determine the types of problems which the students felt ought to be handled by the various men in the academic community who involve themselves with mental health, the respondents were given another set of 10 problems similar to the examples given above. They were then asked, not where they themselves would take these problems, but where any undergraduate could take the problems. The question was worded so as to eliminate subjective feelings that a respondent might have against any group or individual. For example, a student who had no religious affiliation would probably not take certain problems to one of the chaplains, but he would realize that other students might very well do so.

If the number of respondents who stated that a particular group or individual could possibly help a person with that problem is subtracted from the total number of respondents, it is possible to estimate what percentage of the students perceived that group or individual as not handling that type of problem. For example, if the problem had to do with the choice of a major field of study and only 10% of the 140 respondents feel that undergraduates would take such a question to their parents, then 90% of the respondents perceive the parents as not handling such a problem.

By this method 36% (50) of the students perceive the psychiatrist as not handling a problem such as "Feel extremely depressed, and that the world has lost its meaning." The faculty were not perceived as handling personal problems by 65% (91) of the students.

DISCUSSION

There appears to be a highly ambivalent feeling toward psychiatric counseling in college. On the one hand, most students approve of it and feel that it is a necessary part of the college. As stated above, some of this approval probably stems from an increase in knowledge of the field due to the popularity of the psychology courses in personality theory and in abnormal psychology at this university. The increase in literature on the subject and the prominence which this topic enjoys at the whims of current motion picture fashions have undoubtedly contributed to this attitude. However, this approval appears to be largely on the intellectual level, for there seem to be underlying negative feelings toward psychiatry: (1) it is felt that psychiatry is something which should be turned to only as a last resort; (2) few of our respondents would see a psychiatrist if they had a psychiatric problem and many would do nothing; (3) most were ignorant of the existing psychiatric facilities; (4) most did not perceive psychiatrists as giving help on some psychiatric problems.

It appears that a common source for these feelings is a general misunderstanding of the counseling situation, in that many students feel that in seeking help they are transferring the burden of the problem onto the therapist, thereby absolving themselves from responsibility. A member of the faculty remarked that he had noted a tradition among the students that a boy should face all situations by himself in order to prove his maturity. Thus it may be that the students fear any intensive mental health program which might label them as "pampered" or "mollycoddled."

Our findings showed that on many psychiatric problems, about 20% of the respondents said that they would "do nothing," while Cole found that when his subjects were given a hypothetical example of a disturbed neighbor 41.7% said that they would either do nothing or advise the neighbor to take a trip, join a club or get out more often. Thus, the denial of a problem appears to be a common reaction to mental illness.

The lack of knowledge among 70% of the respondents that psychiatric help had been available to the students may represent a lack of extensive publicity on the part of the university, or may be in some way tied in with the students' ambivalent feelings about psychiatry. This ignorance of psychiatric facilities was also found in the Salt Lake City study, where 61.1% of the respondents knew of no local psychiatrist in spite of the existence of an energetic educational campaign in the area. This remarkable ignorance may possibly suggest an element of resistance.

Our figure that 11% of our sample said that they would go to see a psychiatrist if they had a psychiatric problem is comparable with the Salt Lake City study finding that of the 111 persons found to be mentally ill, 11.6% (13) were under psychiatric treatment. Our confirmation of Cole's findings is remarkable in view of the differences between the two populations studied—Salt Lake City, a mecca of the Mormons; and an Ivy League university, a mecca of Joe College.

The verbalized hesitancy of these students to seek psychiatric help when in need of it, and their perception of the psychiatrist as not dealing with many of the personal problems of students is perhaps surprising. It indicates that the educational programs which have been promoting mental health and the intelligent use of psychiatric therapy seem to have failed to penetrate all but the surface—and this among the members of a highly educated group. Such discouraging results might suggest the need for some new educational approach, or at least more sound information about the attitudes of the people at which the educational programs are being directed.

SUMMARY

A random sample of 140 college undergraduates were interviewed to determine their attitudes toward psychiatric and other forms of counseling at the college. It was found that:

1. Their attitudes toward counseling appear to be ambivalent. They encourage counseling in the abstract but are fearful of it in its concrete forms.

2. A large number of students were found to be unaware that the facilities of a university psychiatrist were available to them.

3. A majority of students stated that they were very hesitant to use the services of a psychiatrist and even then would do so only as a last resort.

4. The students did not perceive the psychiatrist as being able to help them with many of their personal problems.

JOSEPH C. SOLOMON, M.D.

Neuroses of school teachers

A colloquy

The schoolroom must be looked upon as a force secondary in importance only to the home in the development of human personality. Psychopathology which may have originated in the home can be crystallized or fortified in the school situation. A child with both stable parents and stable teachers is fortunate. Conversely, emotional problems are aggravated when a child with unstable parents is exposed to unstable teachers.

Parental attitudes are known to be largely responsible for both heathly and disturbed emotional development. It is common knowledge that many behavior problems of children reflect the unconscious conflicts of one or both parents. It is therefore perhaps important to examine the possible effects of unconscious conflicts in teachers as they may affect the emotional development and especially the learning of their pupils.

These attitudes of hostility, indifference, excessive sympathy, seductiveness or indulgence represent, for the most part, unresolved problems within the teacher and need to be understood for effective teaching.

Relationships between teachers and pupils are most significant in the early years, just as they are in parent-child relationships.

Blocking and disability in certain areas of learning may be attributed to poor

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Dr. Solomon, who is a practicing psychoanalyst and an associate clinical professor of psychiatry at the University of California Medical School, read this paper May 13, 1958 in San Francisco at the annual meeting of the American Psychiatric Association. At the same time Dr. Norman E. Zinberg, associated with the late Dr. Leo Berman in his well-known program with Boston school teachers, gave an extemporaneous description of their project that is not part of the published colloquy.

teacher-pupil relationships or may be a screen for other difficulties in the parent-child relationships. However, the crystallization or malintegration of particular patterns may have received the final push from a disturbing school situation in a predisposed child.

The teacher's understanding of his or her own emotional make-up and attitudes to all or particular pupils is important. What we hope to bring out in this presentation is the concept that the classroom can furnish an atmosphere where there is stable leadership and where the emotional interactions between teacher and pupil are understood and handled in such a way as to aid the student's emotional growth and enhance his learning. We also wish to recognize that as a whole teachers are a relatively stable group of individuals, certainly as stable as any other profession. The great stresses and strains to which they are subjected come not only from pupils' problems but from parents, school administrators and boards of education.

Dr. Berlin, who has had considerable experience as a consulting psychiatrist to schools, will continue the discussion.

FROM TEACHERS' PROBLEMS TO PROBLEM TEACHERS

By I. N. Berlin, M.D.[1]

Eight years of psychiatric consultation with several school systems has convinced me that most problem teachers have resulted from certain pressures and practices which seem inherent in many school systems. I have rarely seen a teacher in consultation whose difficulties resulted only from her own personality problems. I have many times worked with teachers whose evident character disorders would seem to preclude their effectiveness as teachers, and yet with wise management and assistance from alert, intuitive administrators these disturbed teachers were doing good jobs in the classrooms. Other psychiatric consultants have confirmed my impressions that neurotic disturbances among teachers are not more frequent than those found in other professions that work with people. Problem teachers seem to result from the same juxtaposition of forces which make for neurotic disability in all human beings—namely, the severity of the stresses, their duration and the susceptibility or predisposition of the individual.

I have felt that the stresses which impinge on the teacher can be divided into two large categories—the external stresses and the internalized ones.

The external stresses are becoming more and more severe. They seem to be unremitting and pose serious problems for the mental health of even the most stable teachers. These increasing stresses result from the ever-larger numbers of children with little motivation to learn, little curiosity in the world about them and very little ability to derive satisfaction from working or mastering a task. Thus, teachers are being faced in their classrooms with growing numbers of indifferent children. They have little desire to learn to read, or to learn at all.

With these ever-larger groups of nonreaders and nonlearners come the resulting increase in behavior problems. Since there are few if any satisfactions from learning for these children, and since they have not been helped by their parents to learn to master environmental problems by regular, continued and steady effort, these children feel constantly dissatisfied, disgruntled and tense. These feelings are expressed in

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acting out, aggressive, hostile, tantrum behavior.

Such disruptive behavior occupies more and more of the teacher's time. She has less and less time to teach the few children who want to learn. The teacher's satisfactions from teaching are consequently being continually reduced. Added to these stresses are the unreal demands of both school administrations and the communities

In the face of these growing problems many school administrators have been demanding that teachers counsel disturbed children and their parents. Thus, to the burdens of attempting to teach unwilling pupils are added the burdens of attempting to counsel troubled parents and children whose hopeless and helpless feelings are often manifested in hostile, defiant, indifferent and demanding attitudes.

The teacher is therefore doubly frustrated and defeated. She is not trained in psychotherapeutic techniques, her efforts to help disturbed children and their parents often backfires and even skilled, well-adjusted teachers begin to feel helpless and ineffectual.

From many communities there are increasing demands, tacitly accepted by some school administrators, that it is the school's job to instill discipline, the desire to learn, cooperative interpersonal attitudes, respect for authority, good work habits, etc. Many parents in our society seem to be desperately looking to others, since they seem unable to look to themselves to exercise the parental roles. Under such pressures more school administrations accept these assigned roles. The evidence accumulated in the last few years is quite clear. It is extremely difficult, if not impossible except in rare individual instances, for teachers to assume the parental responsibilities. The educator faces an almost impossible task with those children who have not been helped to enjoy learning, to delight in the quest for knowledge and to feel the satisfactions that come from mastery of self and the environment.

The pathetic paradox is that all of these increasing demands and expectations are placed on the shoulders of teachers who are ill-paid and yet expected to unselfishly devote all their time to work which not only has little monetary reward but carries ever-fewer satisfactions in actual teaching.

In addition to these external stresses teachers are subject to traditional indoctrination in most teachers' colleges which tends to deny the teacher the right to feel and to express human feelings. Teacher trainees usually are given to understand by their instructors that good teachers feel only love and compassion for their students, and that no matter what the provocation they must never feel hostile, angry, frustrated and hopeless. Teachers who find themselves in difficult teaching situations often feel they have nowhere to turn, no one to whom they can ventilate and relieve themselves of the burdens of suppressed feelings. How often I've heard administrators say, "We just don't get angry. We help all our children with love and patience, don't we?"—this to a teacher beside herself with tension and fury because her best efforts have been thwarted by an indifferent, defiant student. In many schools a teacher knows that any admission of how she feels will cause her to be labeled a poor teacher. In my own experience this burden alone has caused teachers to feel that the strains of teaching were too diffcult to endure, and they have consequently left teaching.

Thus, there are increasing demands on teachers to instruct more and more unwilling, rebellious pupils. In addition, they are expected to take over not only the

parental job towards the children but in many instances to be parents to the parents, or at least to be their psychotherapists. Finally, there are the unreal internal stresses which deny teachers the recognition that their feelings in difficult classroom situations are human, acceptable and must be ventilated and communicated to others for their mental health.

All these teachers' problems tend to make for problem teachers.

The problem teacher is usually one whose psychological makeup results in a particular equilibrium necessary for his functioning but often maladaptive and discordant in the school setting.

As I have tried to understand the problems of the teachers with whom I have worked, I have come to feel that those with learning problems of their own seem to react to stress with the most maladaptive behavior. I have no way of knowing the frequency with which these particular patterns occur in schools.

I have been most interested in these problem teachers who appear to derive little satisfaction from learning. Since they themselves have not acquired the capacity to obtain pleasure and satisfaction from learning, from working effectively and mastering their job, they seem to be especially vulnerable to situations where their students manifest similar problems of the same or greater severity. Thus, they are caught in the dilemma of trying to help others do what they themselves cannot do. Many of them turned to education in the hope that they could get by with little effort or knowledge, only to find themselves increasingly disorganized, harried, frantic and unable to control their classes. If the administrator tries to help by making the job easier, by expecting less of the teacher or doing some of it for the teacher, the problems usually are compounded. These teachers tend to regress the more their work is done for them. They are most difficult for administrators, and I feel they are their most troublesome problems.

For such teachers classroom control is extremely difficult. They often lose their tempers and resort to corporal punishment in a desperate effort to maintain some control of their pupils. The substitution of force for teaching skills and knowledge occurs frequently with these teachers and presents recurrent problems to the administrator.

Certainly any severe neurotic conflicts which reduce the teacher's feelings of self-esteem and worth will result in teaching problems. These may be seen either in overindulgent seductive behavior or punitive harsh actions with pupils. Both extremes are designed to maintain control of their pupils in the face of the violent internal conflicts.

I've been repeatedly impressed with how those administrators who focus on the job of teaching to be done are able to reverse the process from problem teachers to teachers' problems. Their ability to listen to teachers with concern and to expect and insist on a good job of teaching has helped teachers to work more effectively to their own increased satisfaction. In turn, as teachers do more teaching they begin to expect more learning from their students.

When administrators have been helped to delineate their own capacities and limitations as human beings and to accept their own feelings in face of problems and frustrations, they have sometimes adopted more realistic attitudes about the role of the schools. Thus, the administrator is able to maintain that the school's chief role is imparting knowledge and techniques for acquiring knowledge. He helps his faculty to see their role as one of teaching and not

being substitute parents. Then also the human emotions of administrators, teachers and pupils are accepted and allowed ventilation, and more teaching and learning occurs.

In one school, following repeated psychiatric consultation, parent-teacher-administrator conferences were held around each problem child as frequently as possible. In each conference an effort was made to delineate the role of the school and the parents. There were many initial angry protests by the parents. They clamored that the school was failing in its responsibilities to the community. However, later in the year some of these parents in their P.T.A. meetings expressed their appreciation that they were being helped to be more parental with their children. Some parents volunteered that their children were now learning more. Some were beginning to learn for the first time.

I am impressed that the equation from teachers' problems to problem teachers is a reversible one.

Dr. Solomon: It is an interesting commentary that some teachers seem to have a consistently high percentage of problem children and others do not seem to have any. This is similar to the recently disclosed fact that some capable physicians consistently run into malpractice suits and others, who may even be less skillful technically, are never sued. The answer lies in the stability and leadership qualities of the individual doctors.

The classroom situation provides an ideal opportunity to exercise leadership. Principles of group leadership can be applied in the school setting. We do not imply that teachers need to be skilled group psychotherapists, but some of the basic principles can bear elucidation. Dr. Lindgren will take up the discussion from this aspect.

PEDAGOGY AND GROUP LEADERSHIP

By Henry Clay Lindgren, Ph.D.[2]

Both psychiatry and teaching have a common interest in promoting emotional maturity, although teachers differ both from psychiatrists and among each other in the way in which they view the roles appropriate to this function. Both psychiatry and teaching are concerned with helping people learn new ways of coping with the world and its realities. Teachers and psychiatrists alike are regarded as authority figures. The teacher, however, has a dual task. He must be concerned with individuals, but if he is to be really effective in his work he must always keep the group in mind. Most of his planning and presentation is done in terms of the classroom group. Teaching a group of 30 students is not just a matter of teaching 30 individuals—it is also a matter of teaching a *group* of 30. Many a teacher has found that he has one kind of relationship when he works with a child alone and a totally different kind of relationship when the child is with the classroom group. Often the child behaves in one way when in the classroom group and in an entirely different way when alone with the teacher. Some teachers are disturbed by this and do everything they can to keep a group relationship from developing in their classes so that they can maintain a person-to-person relationship with each student. Some teachers will tolerate the group as a group only on their own terms—that is, only if it will be completely subservient to the

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teacher's will. And of course other teachers accept the group and use its dynamics as an aid in teaching.

There are an infinite number of problems that teachers face in attempting to work with the groups and individuals in their classrooms. I wish to first discuss the conflict between autocratic and democratic modes. As the world moves toward greater democracy, we see less and less emphasis on methods based on force, coercion, and reward and punishment, and more emphasis on permissiveness, cooperation, tolerance and mutual respect.

One of the difficulties resulting from this change is that our ideals get ahead of our methods. This means that our desire to deal with children democratically is frustrated by the fact that we have not developed methods and approaches that are consistent with this philosophy. This conflict between philosophy and methodology obviously creates a number of perplexing problems. Many teachers deal with this conflict by using autocratic methods in the firm belief that they are being democratic. A teacher once told me, without any thought of inconsistency: "I run my class democratically. At the beginning of the school term I write the rules of behavior on the board and the whole class votes to abide by them." A few teachers deal with the problem by abandoning controls altogether, in the mistaken belief that democracy is equivalent to absence of authority. Still other teachers continue to use a mixture of democratic and autocratic methods but are continually bothered by the gap between their ideals and their behavior.

One solution to this problem may be found in the mutual respect of teacher and pupil. The teacher needs to respect himself and his pupil as persons who have a right to be valued and appreciated, as persons who are not to be exploited, despised or victimized. From the standpoint of leadership, it can be stated that unless a teacher respects both himself and his students, he cannot realistically expect them to respect him or themselves.

The second problem is the matter of the role played by the teacher in the mind of the child. By tradition and by law the teacher is *in loco parentis*—in place of the parent. The assumption of a parental role can be useful if the student's attitude is a positive one—that is, if he has been able to learn from his parents. Many teachers consciously or unconsciously play a role that is very strongly parental in order to evoke and intensify this kind of relationship.

The problem of the teacher's becoming too emotionally involved with her students has both specific and general phases. Probably most teachers enjoy some aspects of their parental roles. The institution of the "teacher's pet" is an extension of this attitude. Every teacher finds that he likes some students better than others; it is difficult to keep from liking the student who is responsive and eager, just as it is difficult to keep from disliking the student who is bored, insolent or rebellious. Needless to say, teachers who are unable to keep these feelings under reasonable control inevitably encounter difficulties. The teacher who openly favors some students and rejects others creates resentment and hostility —both disintegrative forces within the classroom group. Under such conditions learning becomes difficult or impossible. The teacher may be forced to resort to authoritarian methods which can stifle the student's will to learn, or become so protective that the learning situation is neglected.

A general problem relates to the expectations teachers have with regard to students.

A study of teacher-student attitudes in the secondary schools of Newton, Mass., turned up the fact that the teachers were concerned with maintaining friendly relations with students, whereas the students were not concerned with the teachers' friendship. Thus we have the picture of the teacher looking to students as a source of love and appreciation and being rather chronically disappointed. It is easy to see how the student who shows any warmth toward the teacher becomes a candidate for the role of "teacher's pet."

Teaching is the most exposed of all professions: everyone knows how to educate, except possibly teachers. The public tends to see teaching as a matter of knowing your subject. The need for teaching skill is ignored or derogated, and the understanding of the dynamics of human behavior does not even enter the public's awareness as an important factor. The teaching profession is actively discouraged from making use of research findings in modifying existing curriculum methodology. The educational profession is forced to accept an interference in its areas of technical competence that is tolerated by the members of no other profession.

The public's treatment of teachers has had two kinds of results that are clinically interesting: an increase in anxiety and an undermining of self-respect.

The teacher is like a rat in a maze, each pathway of which is triggered to release an electrical discharge. No matter which way the teacher turns, he incurs some anxiety. If he tries to develop an educational program based on educational or psychological research or on a perceptive understanding of students, he may incur public censure and ridicule. His own administrators very often will not defend him under such circumstances. If he chooses instead to use the traditional methods of autocracy, he fails to stimulate much learning in most of his students. If, as sometimes happens, apathy turns into rebelliousness, he may lose his job for being a poor disciplinarian.

While it may be argued that teaching attracts people who are already neurotically inclined, as one who has been "through the mill" I would like to submit that the strains and stresses to which the teacher must submit are hardly calculated to insure good mental health.

A certain minimum of anxiety is undoubtedly a good thing. It keeps us on our toes and alert. A good teacher, like any other kind of effective leader, needs to learn how to tolerate some anxiety. But when a situation generates more anxiety than can be comfortably handled, the result is far from healthy. One result of a superabundance of anxiety is a narrowing of the perceptual field; the anxious individual is inhibited from finding ingenious and creative solutions to the problems that face him and is forced to fall back on less adequate techniques. He becomes defensive and intensely self-concerned, attitudes inconsistent with effective pedagogy or group leadership.

A teacher who behaves in ways that are defensive, self-concerned or generally ineffectual is not likely to be perceived by his students as richly endowed with self-respect. Nor is he inclined to develop much respect for himself if the public's esteem for him is measured by his salary.

Let us not forget that students, too, are members of the general public. And if they learn outside the classrooms to depreciate their teachers, where can the teacher begin to develop the kind of mutual respect that is essential to good pedagogy or to effective learning?

Teachers are better educated than they used to be. They are widely traveled; few

professional groups know the world as well as they do. They tend to have a breadth of interest and are much more inclined to become involved in the life of the community than they were a generation or so ago.

But their chief source of strength is their interest in their work. Teachers are, by and large, dedicated people. They believe in what they are trying to do. Although their morale has been shaken to some extent by the largely unjustified criticism that has been directed at their profession, most of them continue to bring enlightenment to the young and to take satisfaction in their very real successes. I think it is their ability to find satisfaction in their work that enables them to tolerate as well as they do the pressure and tensions that they encounter in their profession.

Dr. Solomon: As a leader, the teacher becomes an accessory parent. In the lower grades he or she may represent a real parent figure with some of the parent's inherent duties and obligations. When the child's needs have been met adequately at home the parent role of the teacher is quite secondary. But the child may seek collection of an unpaid bill from the teacher when his needs have been unmet at home.

In the classroom situation a good teacher strikes a happy balance between satisfying the needs of the child and expecting cooperation and good work. Such a teacher is revered and remembered as a real person who not only imparted knowledge but played a role in the emotional growth of the child.

When there are distortions in the child's ego development or when there are disturbances in the leadership or integrative capacities of the teacher, distorted relationships take place. A good teacher may find reactions in a pupil which are uncalled for by anything that has happened in the classroom. Children may react to the teacher in a way they would like to or actually do to their real parents by hostile attitudes or clinging dependency. This is, of course, the transference phenomenon familiar to all psychiatrists. Emotions that have been invested in other pertinent life figures are transferred to another person.

Teachers may reflect their unresolved childhood problems by unwarranted reactions to specific pupils. Unfriendly attitudes or extreme attachments towards specific pupils may reflect the emotional needs of the teacher. These responses may be provoked by the pupil's own transference reactions. For this reason the term countertransference is employed.

Dr. Baruch will take up the discussion of the phenomena of transference and countertransference.

TRANSFERENCE AND COUNTERTRANSFERENCE IN THE CLASSROOM

By Dorothy W. Baruch, Ph.D.[3]

Many definitions of transference and even more varied ones of countertransference exist in the literature.

Freud stated, "The patient puts the analyst in place of his father or mother. Thus he becomes a new superego [which] now has an opportunity to correct blunders."

We could parallel this in the school situation and say with equal validity that "the child puts the teacher in place of his father or mother" and that the teacher similarly has the opportunity of correcting emotional blunders, at least where blunders have not been too traumatic and where

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the child has not grown too disturbed. Here the teacher's own emotional reactions, his countertransference, enters. His feelings, derived from his past, play their part. In teachers there are countertransference derivatives that might be expressed as "I have to be the ideal parent in my relationships with these children." As long as the teacher can be the ideal parent, sweet and calm, gracious and giving in gesture, and as long as the children remain "little dolls," the picture fits in, moreover, with what the edicts in teacher-training usually claim a fine classroom atmosphere should be like. The transference-countertransference interactions then stay positive.

But obviously many emotional cross-currents interfere. In bringing you some of these I shall draw on experience I have had with teachers over the last quarter of a century both in teacher-training and in group and individual psychotherapy. I shall quote mainly from tape-recorded sessions of a teachers' workshop that has been in process since March 1954, in which teachers from kindergarten through high school have dealt particularly with children's feelings and their own.

The most frequently disturbing pattern of transference-countertransference interaction that we have seen accrues when children act out hostility—indirectly and unavowed—through disobedience, inattentiveness, not turning in assignments or turning them in "messed up" or late, through whispering, quarreling, "goofing off" and "horsing around."

In some instances the situation gets out of hand because in the attempts to maintain an ego-ideal of the "giving" parent the teacher unconsciously wishes to overthrow the introjected, authoritarian, demanding parent. And so, he or she fails to provide the firm leadership that children need. Says a first-grade teacher, "I feel like a witch when I'm strict. I keep backing down then and the children invariably take advantage." Says a sixth-grade teacher with greater insight, "I had a big struggle with myself in working out where strength was good and where strength was bad, and where I was being like a bad mother and where I needed to be strong. And I came to see that what I had thought was punitive really wasn't. It was actually sticking to needed rules. Since I worked it out for myself, my children work much better."

Sometimes too great permissiveness appears to be a defense against a teacher's revealing hostilities toward actually demanding objects in his past. To quote one teacher, "The children loom up like 37 monsters, each yakking as loud as my mother did." "Demands, demands," says another. "I feel as if they're beating me with their demands and that I have to keep on sweetly saying 'Yes.'"

On the opposite side, some teachers carry out in the classroom the same sort of thing that we have seen youngsters depict in paintings where they draw themselves as gigantic figures beating or smearing their parents, whom they draw very small. Such teachers make the children into parent figures shrunken into nonthreatening dimensions. They carp and criticize and use the children in one way or another as objects of their own ancient hostilities.

As a flagrant example of a teacher's taking hostility out on children, a fifth-grade male teacher read a story to his classroom in which a Corsican boy accepted bribes from a thief, which so offended his father's pride that the father shot the son. Totally unconscious of the sadism involved in the story, this teacher avowed that he read it "just to have a little fun. I like to see their reactions." My workshop members questioned his motives, and during the dis-

cussion that ensued he came out with "My own frustrations have always overwhelmed me." Meanwhile, his rigid classroom discipline and sadism had led his pupils to displace their aggression onto each other. "Someone is always beating someone else up as they come in the door." Concomitantly the achievement level in this teacher's classes was consistently low.

A man teaching the fourth grade has all his life "been in revolt." He permits pandemonium in his classroom. He says, "I think a certain amount of naughtiness in children is desirable." But he lets it get too extreme and then has to "use the paddle, which," he says, "relieves us all." Thus in the countertransference he acts out; he lets the children be naughty and then he gains restitution by punishing them as representatives of his guilty self.

Occasionally a teacher appears to take children as siblings. A high school teacher, for instance, finds herself "picking on" a particular popular girl. "My sister was glamorous; I wasn't" shed light on the matter when it slipped out one day. Another teacher, who had had numerous younger siblings to care for, continuously complained that "the children weigh me down."

In contrast, we have worked intensively on how the transference-countertransference interactions can be used as assets in the school situation. We include such qualities as understanding and acceptance —of feeling "with" a child because within oneself one knows how he feels. It enables the teacher to react in positive fashion to transferences from the child.

We have found that it helps to make the countertransference positive when the teacher can see that often children want from him what they have emotionally wanted at home. It helps the teacher to see that often transference behavior attempts to elicit attitudes that the individual has not had at home. What we have found helps most, however, is for the teacher to recognize that children transfer onto him their negative and hostile feelings towards their parents. This often relieves the teacher of unrealistic guilt, self-condemnation and a needless sense of failure.

In short, meaningful awareness of the psychodynamics of childhood and how children bring a multitude of feelings from home into school often enables the teacher to give to the children, in ways appropriate to the school setting, adaptations of what Franz Alexander has called the "corrective emotional experience."

Teachers are helped, too, to make such adaptations when the difference between indiscriminate acting out and "channeling" of feelings is clarified.

In a B-11 United States history class—that is, with 15 and 16-year-olders—the subject of freedom was being discussed. There were muttered swear words, throwing of erasers, sly passing of notes, general disorder. These the teacher recognized, to quote his own words, "not as an affront to me, as I might have formerly. But I knew they were mad. And I thought: Better get it out legitimately. So I said, 'You seem bothered and mad at me or at somebody in connection with this business of freedom. Suppose you write out how you really do feel. Anything goes in the writing. But no more swearing, etc. Here is a way to get out your anger.' " To give just a simple single sample of the transference evident, I quote in part one boy's paper: "There is supposed to be freedom in the U.S. But the teachers tell me what to do. The principal tells me what to do. We can't talk. We can't be late. We can't chew gum. We can't do anything but our own school work which is terrible.

It's the same at home. The old lady tells me mow the lawn, sweep the patio, do this, do that. The old man comes home. 'You forgot to do this. You forgot to do that. Leave your car in the garage and walk to school.' And there it starts all over."

To skip down to lower levels, a number of teachers have given children chances to bring out how they feel about their polio shots. In one kindergarten several children made clay mothers and clay teachers and "mashed them up cause they hadn't ought to let the doctor to it," showing mother and teacher taken as one. (Incidentally, at all elementary levels teachers report that children inadvertently address them as "Mother" or "Father," "Mommy" or "Dad.")

In another kindergarten a little boy persistently buried a ball in the sandbox, kicked it and hit it. "I'm spanking you, Mrs. Hall," he announced. The teacher said, "You'd like to do that sometimes." He hit some more, "I'm hitting your husband. I'm angry at your husband." The teacher nodded. "I think maybe you're angrier at somebody else's husband." And he said, "Yes." He was "angry at Mrs. Webster's husband"—his father—and he added, "Angry at Mrs. Webster too. Just like at you." "I know" said the teacher, "All little boys get angry at their mothers and fathers sometimes and want to hit them or hit their teachers instead. They can't really. But they can hit the ball . . . or ?" she turned and questioned the cluster of children who had gathered around. "They can paint hitting pictures," one child volunteered. "Or throw bean-bags," said another. "Like we'd like to do at you sometimes." "But can't."

In handling stress situations between children, it helps also for teachers to realize that derivatives of the sibling relationship are often involved.

Another question current in psychotherapy is also important in the school situation: Shall the therapist—or in this instance the teacher—share countertransference reactions? In the classroom we have come to see that the teacher's verbalization of feelings makes for more positive interactions. We have found that the atmosphere remains more wholesome and the children's work progresses better when teachers are able to share their feelings, not to absolve the venting of anger but as one means of offsetting the necessity to do so.

Children in the classroom acutely perceive how the teacher feels.

In a first grade, for instance, a teacher slammed a book down on her desk, feeling she'd like to slam one of the noisy little children. The children caught it. One said primly, "It's no good for us, Mrs. Allen, when you slam books." Another said more resolutely, "I feel like you're slamming me."

In a mixed grade of elementary school children with hearing disabilities, a teacher found herself feeling very annoyed and abused because the children were not jumping in to help her clean up the paints they had used in a harbor unit. To give her own account: "They sat like little mummies, all staring. No one did anything. Finally I caught myself and I said, 'I'm mad at you.' And Nina said, 'Boy, you *are* mad. I guess you feel like when your mother used to make you do all the work!' She knew! . . . I said, 'Yes.' Then they all started grinning. And boy, they buzzed into it! And we all felt very solid and good."

As a fourth-grade teacher summarized it: "If I say how I feel, the children seem to feel safer. Even though I don't know what it goes back to or why, it's there."

Obviously what we have been talking about here are the conscious derivatives of

the countertransference. In some teachers the unconscious parts may call for far deeper psychiatric help.

Not all teachers, however, can have the benefit of psychotherapy. But all teachers could benefit by having the psychiatrist become one of the important teachers in the education of every teacher today.

Dr. Solomon: It is gratifying to report the growing appreciation and understanding by school teachers of their deep-seated reactions to their pupils. This is demonstrated by the increasing number of teachers who seek psychiatric assistance for their personal problems. A generation ago a teacher would have jeopardized her job and been stigmatized if she had consulted a psychiatrist. If my experience is typical I can say that there are hundreds of teachers who are or have been in some form of psychotherapy. I have learned a great deal about the interactions of teachers with their pupils, administrators and parents from the psychoanalysis of several school teachers.

One teacher reported an especially unfriendly attitude towards one of the boys in her class. She was particularly irked by his aggressiveness towards little girls. He shoved, taunted and molested them in every possible way. The teacher recognized that her hostility was out of proportion to the harm done by the boy. By means of her associations she recognized that she was displacing aggression from a different source onto this boy. Her daughter had a romance with a particularly obnoxious sailor who had first definitely forced his attentions on her and later disappeared. The girl developed a serious mental depression. This situation was fresh in the teacher's mind when she reacted to the boy in her classroom for treating the girls as the sailor had treated her daughter. When she recognized the source of her feelings she was able to deal with this pupil more realistically.

Another teacher said during analysis that her whole classroom attitude had changed. Formerly she had spent a good deal of time insisting that all the desks be exactly in line and everything else compulsively orderly. She was able to relax her unnecessary rigidity. She admitted that she must have made her pupils miserable with her authoritarian demands.

In closing this colloquy let me reiterate the statement made earlier—namely, it is not recommended that teachers become either individual or group psychotherapists but that they learn enough about the reactions of their pupils to themselves and of their unconscious reactions to pupils so that they can teach more effectively.

LEO EITINGER, M.D.

Psychiatric investigations among refugee patients in Norway

With some remarks on the causal chains in mental disorders

Ehrenteil (1) introduces his study with Overholser's observation about two separate causal chains which together produce the clinical picture of psychosis. This observation is of importance for all countries which carry on psychiatric research. The swing of the pendulum between somatic and psychologic viewpoints of the cause and treatment of mental diseases was more extreme in some countries than in others. Norway is among those countries where this swing was fairly moderate, a fact which is perhaps due mainly to the influence of Norway's first professor in psychiatry, Ragnar Vogt (11), who formulated his view on the great controversial questions of the period in Adolf Meyer's spirit: "not either-or but both-and." Ehrenteil's demonstration that "one group of causes, the pathologic-physiological, produces the disturbance in mental functioning which allows a break with reality, while another group of causes, the psychodynamic and social motivations, determines the direction which the psychotic deviation will take" is the modern expression of the above-mentioned quotation.

A scientifically valid confirmation of this opinion can best be obtained by investigating large groups of patients in whom one can reasonably expect to find the same psychodynamic and social motivations to see how far they, independent of the pathological-physiological causal chain, show the same symptomatology with regard to the

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direction of the demonstrated psychopathological changes.

The author has carried out an investigation of this nature in connection with a psychiatric estimation of refugee patients in Norway, and has reported this in detail elsewhere (3). In this paper we will merely refer briefly to the data which is pertinent to the matter before us.

"The average refugee population" of Norway was found to consist of 1,789 persons. Of these 60 became psychotic in the observation period (January 1, 1946 to December 31, 1955), which is 3.19% of all refugees. All the patients who at the time of the investigation were still in Norway were personally examined by the author. The observed incidence for all diagnoses was 60 in the refugee population, compared to 11 which could be expected in a corresponding Norwegian population group.

It is a general and almost certain experience, confirmed, among others, by A. Kerenyi, E. K. Koranyi, and G. J. Sarwer-Foner (6), that paranoid reactions and paranoid states are very frequent, and certainly more frequent among refugees than among other population groups. This fact does not warrant any special comment. What proved to be remarkable in the detailed examination of the case histories and the personal investigation was, however, that those patients who could not be classified under these headings also showed massive persecutory traits. This was shown perhaps most clearly in the 4 patients with chronic brain disorders who appeared in the group investigated. The two causal chains could be most easily explained here, and from the case histories it will be seen that both of these were decisive for the completeness of the picture of the illness.

The first patient was a Polish, Roman Catholic laborer, born in 1917. During the first days of the war he had been taken prisoner by the Germans, and since then he had had to work as a slave laborer in different camps in Germany. In 1943 he had his first epileptic attack and in 1944 his eyesight started to fail. He was not examined by a doctor until after the war and then it was proved that he had a glioma, for which he was operated on in 1946. After the operation he became totally blind (amaurotic), but was otherwise physically fit. He refused to return to Poland, married in one of the camps and lived there without any physical difficulties. Like all other camp inmates, he did no work.

In 1950 he was sent together with other blind persons to Norway with the intention of finding some employment for them. This change of environment in addition to the new demands made on his ability to adjust were too much for the patient. He rapidly became paranoid, thought that his life was in danger, that he was going to be poisoned or killed, and had to be hospitalized. His condition deteriorated considerably in the hospital. He not only suffered from delusions of poisoning but he also thought that his wife, who was not blind, had had him put in the hospital so that she could marry somebody else. He heard his wife and her lover in the room next to his. The doctors, nurses, social worker and so on, were all helping to get the wife married. Everyone was against him, because he was a blind foreigner. At the same time he also showed every sign of organic dementia and died after only three months in the hospital.

The next patient was a 44-year-old Polish Jew, a skilled worker, who had grown up in a quiet and harmonious home under good social conditions and had had an orthodox religious upbringing. During the war he and his family were arrested and both his parents, his siblings, wife and children died. Strangely enough, he him-

self survived, in spite of serious famine edemata, typhoid fever, extreme emaciation and a rheumatic joint disease. After the war he was found to have tuberculosis, and he was treated for this in various sanatoria in Germany. He remarried, but his wife died of tuberculosis only two years after the marriage, and without having had any children.

He was brought to Norway in a tuberculosis transport and admitted to a sanatorium. Here he was the only Jewish patient; there were no Jews in the town near the nursing home either. The official, Protestant public holidays were celebrated in the sanatorium, and there were, moreover, a number of religious events, devotional meetings, visits by priests and so on. The patient soon felt that he had been chosen for conversion by everyone, that they wanted to get rid of him because of his Jewish faith. He was convinced that everybody was talking about him. Finally, he became hallucinated, overheard plans for killing him, thought that a fellow-patient was trying to break into his room one night in order to kill him; he saw the glint of the knife. In wild panic he fled through a window and ran away, clad only in his underwear. On admission to the psychiatric department of the university hospital, he showed, besides these massive paranoid reactions, clear signs of a chronic brain syndrome. He could not remember the most ordinary things (his case history had to be reconstructed on the strength of the information given in his papers), and the psychological tests supported the diagnosis. A pneumoencephalogram showed a dilation of the side ventricles and dilated sulci.

During his stay in the hospital we were able to win the patient's confidence, and the paranoid reactions disappeared completely but the symptoms related to the chronic brain syndrome showed a negligible improvement only. He was able to be discharged after two months to another tuberculosis sanatorium. However, the same thing was repeated here. In spite of the fact that he was very badly off financially, he would not eat the hospital fare; he said it was poisoned and "what is more, it is not 'kosher'," he preferred to live on rolls that he bought elsewhere. He soon started to think that his life was threatened, and he had to be hospitalized once more. A rapid remission again occured. After this, we succeeded in placing him in an environment in which he felt safe, where he made friends and could cope with simple work.

It was originally supposed that Alzheimer's disease was present, but the later relatively benign course seems to denote that this was a case of famine atrophy. This appeared in a number of concentration camp prisoners, and is described in detail by Thygeson et al. (10).

The two other patients—one had a chronic brain syndrome associated with senile brain disease and the other a chronic brain syndrome associated with central nervous system syphilis—showed completely analogous pictures of illness.

In all these cases it was clear that the formation of the paranoid delusions was determined by the patients' psychological situation, but the organic process and its symptoms had a parallel course with constant interaction of the two causal chains.

Case 2 also shows that the integral strength of a patient can be influenced by an adequate adjustment of external conditions, even though a chronic brain syndrome may be present. This strongly supports Ehrenteil's and Neustadt's observations, and these are further emphasized in Norway by Houge (5) among others and by the author in a previous paper (2).

The observations presented hitherto do not, however, give any answer to the question whether two separate causal chains may not also be assumed to be present in so-called "functional" psychoses. With regard to general paranoid reactions, we have not been able to find anything to support this assumption in the present investigation of all psychotic refugee patients. In all cases it was clear that situation-conditioned reactions precipitated and determined the psychotic development. The refugee existence with its insecurity was in most cases the decisive factor. This fact best explains why the observed incidence for the paranoid reactions is more than ten times higher than could be expected in a corresponding Norwegian population group—that is, 42 against 3.518. The course was benign, and, prognostically speaking, there was no difference between the refugee patients and a group of matched Norwegian psychotics of the same symptomatology.

The circumstances are quite different, however, with regard to the real schizophrenias. The author has been exacting in his demands to warrant this diagnosis, which in brief may be said to have to comply with the following criteria.

In a schizophrenic splitting phenomena with clear consciousness are considered characteristic, along with association disturbances, autism and primary delusions. To the splitting phenomena belong clear ideas and feelings of passivity (resulting, among other things, in "thought reading," "thought-stealing" and so on), derealization and depersonalization which are accepted by the patient without comment. For further details we refer to (4, 7, 8, and 9).

The observed incidence of schizophrenias is 14, compared to 3.964 that could be expected in a corresponding Norwegian population group.

All of the 14 schizophrenic refugee patients have paranoid symptoms. This in itself is not so remarkable inasmuch as the schizophrenias, apart from the classic hebephrenic forms, are often characterized by paranoid delusions. Our refugee patients, however, have persecutory delusions, which always introduce the actual picture of the disorder. The following example, which may be taken as a paradigm for all our 14 schizophrenic patients, shows this clearly:

The patient is a Polish, Roman Catholic, unmarried man, born in 1917. His parents are probably dead. He had not completed his schooling and had started to work on farms at an early age. He had come to Norway during the war and had spent it in a camp for forced laborers. After the liberation he chose to remain in Norway. He worked on different farms, was considered a steady and good worker and was regularly employed. He did not seek many contacts with other Polish ex-prisoners, was considered by them as rather an introvert.

Some time before hospitalization he received a letter from the International Refugee Organization (IRO) questioning him about his home town. He took this extremely seriously and became very anxious. He went to the police and complained that he was being persecuted, accused of spying and sabotage. The police referred him to a psychiatrist, but the patient refused to take any medicine, thought that it was poison and that the doctor was trying to get rid of him. In the mental hospital he showed further persecutory delusions, was hallucinated both visually and aurally, and had feelings of passivity and ideas of influence. He deteriorated in spite of ECT and insulin coma treatment. Later on, drug treatment was tried without any result.

The personally and politically insecure social situation of a refugee is, without

doubt, of the greatest importance in the development of the psychosis. A "relatively unimportant" happening, misinterpreted by the patient, is sufficient to start the psychotic process. This "relatively unimportant" happening has, however, touched on the patient's central problem—his feeling of insecurity—and the paranoid development is set going. It is, however, obvious from the course of the disease and from the case histories of all our schizophrenics that the persecutory delusions are only a pathoplastic feature in the picture of the mental disorder. In the course of the schizophrenic process these persecutory delusions become of less importance to the patient. He is not so preoccupied with them, even though they are still present, a fact which the author has been able to demonstrate in many patients by his follow-up investigations.

In summing up, we may say that we find the same persecutory delusions in patients with both paranoid reactions—with schizophrenias and with chronic brain syndromes. It should therefore be justifiable to assume that it is the same psychodynamic causal chain which brings about these symptoms. In the first group we mention the main causal condition appears to lie in the actual reaction between the individual's personality and the environment; other causal chains seem to be of far less importance. This assumption is supported by the extremely high incidence (42 observed cases against 3.5 expected) and the good later results.

In the latter—that is, in schizophrenias and chronic brain syndromes—there are other factors besides the psychodynamic causal chain which determine the development. In chronic brain syndromes the other causal chain at least is partly known. In the schizophrenias we have little knowledge of the other causal chain. However, the present investigation appears to support strongly the assumption that it does exist and exercises its influence on the formation of the disease and final development. The typical schizophrenic symptoms in the depersonalization and derealization point very strongly in the direction of a pathophysiological component in the "specific schizophrenic causal chain."

The present investigation of psychotic refugees in Norway has been able to show common forces with psychodynamic effect due to the patients' lack of security and with a projection of their insecurity. Moreover, it has been able to indicate that even though this causal chain is common to all refugee patients and influences practically all pictures of the disease, the latter very considerably and their course is determined by the other causal chain, which is known in some cases but unknown in others, at least for the moment.

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JACOB SWARTZ, M.D.

Emotional reactions of patients and medical personnel to respiratory poliomyelitis

Although great strides have been taken in the direction of decreasing the incidence of or preventing poliomyelitis, new cases appear. Apart from this consideration, old cases remain. That the damage caused by the disease goes beyond physical disability and creates problems in the personal life of the patient, in his family and in hospital management has been the subject of reports in the literature (1, 2, 3, 4, 5, 6, 7). Those patients with bulbar poliomyelitis and respiratory paralysis who require confinement in a respirator or require artificial assistance with breathing are the most severely handicapped, require complete physical care and have more recently been the subjects of study from the point of view of their emotional reactions (8, 9). Prugh and Tagiuri (10) especially in a comprehensive review of the literature, in addition to an extensive study of their own with such patients, have delineated in detail many of the problems that arise.

PATIENT REACTIONS

The material for this paper was obtained from a study of 6 patients who were confined to respirators and from a study of the medical personnel responsible for their care. Concern had arisen over the deteriorating morale of the patients, their increasing complaints about their care, their increasing demands, and the difficulties the personnel were having in dealing with them. Informal interviews with the patients did indeed establish the fact that they were complaining and demanding

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and, in addition, the fact that they felt helpless, depressed, anxious, dependent and hopeless and that they were expressing feelings and reacting to feelings, each in his own particular way. Further observations and interviews made it possible to delineate these reactions more specifically.

Thus, the patients understandably wished close and individual attention and became angry, uncooperative or anxious when it could not be provided to the extent desired. At the same time they sought approval from the medical personnel and were emotionally dependent upon them, although this was little recognized by the patients. Most particularly were the patients dependent upon the nurses; they sought approval from them and reacted with apprehension when the nursing personnel was changed. The patients were sensitive to all changes in personnel and routine so that food, time of eating, amount of food, position in the respirator, time of turning the television set on and off became matters of primary importance. They were also very much interested in the personal lives of those looking after them. Furthermore, they got to know a good deal about their nurses and doctors and physiotherapists, sometimes more than the various individuals would want anyone to know.

All in all, our findings in this area are in agreement with those of Prugh and Tagiuri (10), who in addition emphasize the denial, projection and primitive fantasy. Of these 6 patients with whom sexual matters were discussed, attempts at active suppression of sexual thoughts by the patients were revealed.

Much friction had arisen on the ward over the issue of time spent by the patients in and out of the respirator. As a group the patients were made anxious by the prospect of leaving the respirator and were loathe to do so. With encouragement this could be accomplished, but then differences arose as to how much time out each patient could tolerate. Because of this background of tension, the views of the patients about the respirator were investigated.

The most striking and immediately available fact obtained was that each patient felt ambivalent toward the respirator. Being in the respirator represented all the tragedy of the disease—the immobility, the restriction of the environment and the active dislike of being in it. At the same time, however, the respirator came to be experienced as a part of the body, and anxiety was evoked by the prospect of being away from it even for a short period of time. Glud and Blane (9) have written about the body image changes in such patients and of the meanings to the patients of the various types of equipment used in their care.

In addition to the effects of the disease *per se* we must consider the impact of the disease upon the preexisting personality of the patient. The reaction of the patient was a composite of the physical and emotional effects upon him of the disease in the current situation and upon his prepoliomyelitis physical and emotional equipment. Accordingly, depression was more prominent in one patient, denial in another, demanding behavior and hostility toward medical personnel as authority figures in a third. In addition, all these patients were completely dependent upon others for their physical needs and were readily stirred to anxiety or moved to anger or petulant and demanding behavior. These patients required constant attention, were, in fact, physically dependent upon the respirator and very quickly became emotionally dependent upon it as well, and upon the medical personnel. The constancy of the care and attention that was

needed by them constituted a daily drain upon the emotional resources of those concerned with this care.

REACTIONS OF MEDICAL PERSONNEL

Robinson and Finesinger (11) have commented upon the issues facing medical personnel in dealing with patients with poliomyelitis. "To the attending physician who does not realize that his own appraisal of reality fits poorly with that of the patient's this is no problem: the physician will continue to be baffled by or will simply ignore the relationship difficulties which he does not understand. To the more insightful physician who realizes that his own judgment is but one of several perceptual wholes relating to the illness it is an issue which must be grappled with . . . other professionals . . . may acquire a greater measure of responsibility for the treatment of the patient . . . the physician may be aware that a part of his role is being usurped by others and with this feel threatened." The authors go on to point out that interprofessional tensions may then arise as a result of which the patient is likely to suffer.

We observed a variety of reactions in the medical personnel—physicians, nursing and attendant staff, physiotherapists were all affected in one way or another by respirator ward duty. Some staff people were consciously and at first acutely aware of anxiety in dealing with these patients. In others, guilt was mobilized, and still others tended to identify with the helplessness of the patient. A certain measure of firmness and encouragement was always required in acclimating the patient to some period of time daily outside the respirator. A similar attitude was usually required in helping the patient tolerate a certain amount of discomfort during physiotherapy. When the physician's anxiety and guilt were high, his inclination was to be lax in the performance of these important therapeutic tasks, particularly when the patient objected to them.

Other of the medical personnel denied or were not aware of any anxiety. In consequence, they manifested certain characteristic behavior such as avoidance of or minimal contact with the patient. In the physician this took the form of perfunctory ward rounds or absence from them if this could be arranged. During rounds the physician focused his attention on the respirator or upon the chart and in some instances hardly looked at the patient. The patients were, of course, aware of this minimal personal attention and often played games during rounds in which they said they were hemorrhaging to death and then joked among each other about the fact that the staff had been so busy with rounds that the comment had not been heard.

This kind of avoidance by the physician had its effects on the rest of the staff in that discussions with the nurses revealed that they felt what they considered to be a lack of interest by the physician. The nurses indicated that they felt alone or abandoned by the physicians and that not enough interest was shown in the patients or in the problems the nurses had in ward management.

Still another variant in the staff's methods of defending against anxiety had to do with the denial of the effects and implications of the illness upon the patient. This often paralleled a similar mechanism of defense on the part of the patient. In practice, this type of staff defense meant that the physician or nurse expected complete recovery or steady improvement and became insistent, for instance, upon certain specified daily increments of time spent in the

respirator or expected the performance of tasks of which the patient was physicially incapable. Since the performance was rarely if ever forthcoming, these people not infrequently found themselves becoming angry or impatient with their charges or pushing them beyond their tolerance.

A special word is in order concerning the nurses. To understand the role of the nurse in this setting, one must above all recognize that the nurse had a position in the front line of exposure to the intense (though often unrecognized) emotional forces mobilized in this setting. The nurse was exposed to the patient all day every day, to his relatives, to his reactions to his illness, to her, to the hospital and to the physician. The nurses reacted with the defenses appropriate to their individual personalities. Some nurses could not long withstand the anxiety and requested transfer. Others were prone to coerce patients into excessive activity. Still others became especially attached to one patient and overly permissive and attentive to him with the consequent tendency to avoid the others.

Some few members of the staff became overly rigid, authoritative and coercive in dealing with the patients. This applied not only to physical care but to visiting hours, recreational activities and setting hours for going to sleep. Such a physician or nurse found himself becoming increasingly angry with the patients and expressed his anger directly to the patient or indirectly by insisting that the patient was not staying out of the respirator long enough or was not cooperating sufficiently during physiotherapy. One such staff member insisted that the greatest danger in dealing with the respirator cases was to feel sympathy for them since if one did feel sympathy for them all was lost.

Our attention was directed also to the obviously increasing tensions and disagreements among the staff. Some physicians were critical of the ways of other physicians, and some placed the blame for morale and ward management problems upon the nurses. In turn, the nurses felt they were being asked to do the job alone. The physiotherapists felt isolated too. The various physicians and nurses became reluctant to communicate with each other, or if they did communicate it was in terms of criticism, one of the other. Typical nurse complaints had to do with the physician's lack of interest in or knowledge of the patients.

PATIENT MANAGEMENT

Exploration and recognition of some of the sources of patient and personnel anxiety evolved into the need for some attempts at correction. Extensive psychotherapy with the patients seemed neither warranted nor feasible. The collecting of the data in itself afforded some opportunity for simple ventilation by the patients. It was further obvious that the correction of misunderstandings would have to be undertaken by the staff itself, and by way of guidance the data collected from observations of the patients were made available to the staff with some recommendations for ward management. Thus, neither overly permissive nor overly authoritative management was suggested. Some things which in the lives of those not confined to a respirator might seem trivial were very important under these circumstances; giving the patients a preference in choice of food, visiting hours, hours of television watching, though apparently mundane, was of considerable significance to them.

STAFF

In an attempt to clarify some of the issues

involved and to improve communication among the medical, nursing and physiotherapy staffs involved, regular staff meetings were agreed upon for the purpose of discussing the respirator patients. Our intention was to conduct these meetings in accordance with the principles of group therapy but with the focus on the patients and reactions to the patients rather than upon problems of the group itself or of any individual staff members.

During these meetings many of the attitudes and anxieties already referred to became manifest, although not necessarily recognized. The meetings did serve the purpose of ventilating some staff complaints and irritations; they did lead to a recognition of differences of opinion concerning personal views in patient care. However, no far-reaching changes in the feelings of any single individual took place insofar as could be determined. The meetings were discontinued when changes in staff personnel made continuity impossible.

Although a group program that extended over a longer period of time would be necessary in order to draw any definite conclusions as to its value, sufficient material did come out of this group to give the impression that such an opportunity for staff communication is valuable for staffs concerned with the care of respirator patients and of other patients with chronic physical diseases requiring prolonged hospitalization in the same institution.

SUMMARY

1. A study of the emotional reactions of six patients who were confined to respirators because of bulbar poliomyelitis and of the emotional reactions of the medical personnel responsible for their care is reported.

2. As a group the patients had feelings of anxiety, hopelessness, helplessness and depression. The anxiety was often manifested in dependent, demanding, angry or uncooperative behavior. To a varying degree the patients denied the implications of their illness.

3. The constancy of the care and attention that was needed by these patients constituted a daily drain upon the emotional resources of those concerned with this care. The medical personnel responded to the anxiety inherent in this situation in various ways. Some were aware of the anxiety; others denied it. Some experienced a sense of guilt; others displayed overprotective behavior. Some staff people tried to avoid the patients; others became coercive or excessively authoritative. Tension and misunderstanding arose among patients, nurses and physicians.

4. An attempt was made to help with the ward management problems that arose by assisting the staff in recognizing the patients' reactions as well as their own to the disease.

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The general practicing physician as a resource for the mentally ill

As attempts are made to indoctrinate the public in seeking help with mental illness, it becomes of interest to sample from time to time the effectiveness of such efforts at public education. Recently an opportunity was provided to obtain some information relative to the present status of the general practicing physician as a resource for the mentally ill and their families. This information was obtained in a study of the prehospital medical histories of 100 patients admitted to the Spring Grove State Hospital in Maryland in 1958 (1).

The study was conducted by the hospital's department of medical research in connection with a project to compare the relative effectiveness of 6 phenothiazine medications in treating acutely disturbed patients newly admitted to a state psychiatric hospital. This project (MY-2152) was financed by a grant from the National Institute of Mental Health and administered by the Friends of Psychiatric Research, Inc. of Baltimore.

The findings provide a partial answer to one of the questions posed for further study by Charles F. Mitchell, director of the division of mental health of the Texas state health department, at the conclusion of an article in the October 1958 issue of *Mental Hygiene:* "To whom do families turn for guidance when they first recognize symptoms of severe mental illness in a family member?"

Although the comparative drug study was not concerned with guidance resources in general, it did reveal the medical treatment resources of the first 100 patients admitted to the project—men and women between the ages of 18 and 65 who were not alcoholics, who displayed no evidence of any acute or chronic brain damage and who were considered by the hospital psychiatrists to be good candidates for pheno-

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thiazine tranquilizers on the basis of such target symptoms as hyperactivity, hyperemotionalism, aggressiveness and the general appearance of acute disturbance.

In the group were 40 men and 60 women. Fifty had been admitted previously to psychiatric hospitals, and 50 were admitted for the first time. They came from an area in Maryland covering the full range of urban to rural environments, and from a wide variety of social and economic levels. More than 70% of the diagnoses were various types of the schizophrenic reactions; among the other diagnoses were personality disorders, anxiety reactions, manic-depressive psychoses, psychoneurotic depressions and drug addictions.

For 22 of these 100 patients the histories show that, whether or not they recognized the symptoms of mental illness, they made no effort to get medical treatment. All of these came to the hospital as a result of intervention by outside agents—in all but 3 cases, the police.

For an additional 17 (of whom 12 had previously been hospitalized), the state psychiatric hospital was the first medical resource to which the patients and/or their families turned; they applied to other community agencies only during the admissions procedure. One family took their patient directly to a private mental hospital. There is no way of determining the extent to which the hospital was considered by these 18 and their families as a medical resource, as distinguished from a place of confinement or retreat.

There were 60 patients with records of applying for extramural medical help. Of these 42 had turned first to physicians who were not specialists in psychiatry—39 to men in general practice, 2 to obstetricians and 1 to an internist. Seven others turned first to psychiatrists in private practice, 7 to general hospitals, and 4 to psychiatric clinics.

For 11 patients the nonpsychiatric physician was their only medical resource before admission to the hospital. For 30 more he was the principal source of whatever treatment they had received.

Only 30 of the 60 who had sought extramural medical treatment reported that they had done so as soon as symptoms of mental illness appeared. The other 30 acknowledged in retrospect that they had delayed in seeking treatment, some for only two weeks, many for more than a year, and one for nearly nine years.

Further analysis of the data accumulated in this study is in process to determine the kinds of medical treatment these acutely disturbed patients received before they entered the state psychiatric hospital, and, if possible, what factors are responsible for the failure of so many of them to get medical treatment which might be considered adequate. Professional authorities and the lay leadership of the Mental Health Associations are currently engaged in a variety of efforts to reduce the traumatic effect of mental illness on the patient, his family and his community. The findings in this study and in other studies of the prehospital and posthospital experience of the mental patient may well serve to indicate what kinds of educational programs and what kinds of community services may best serve this purpose.

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DOROTHY DURLING

State hospitals make a new start in vocational rehabilitation

According to Linder and Landy [1] research in the vocational rehabilitation of psychiatric patients has been of a "limited and pioneering nature." This is particularly true of state hospital patients, about whose vocational rehabilitation even less has been reported than about other psychiatric patient groups, such as patients discharged from Veterans' Hospitals, psychiatric clinic patients, etc.

There are a few outstanding exceptions. In 1947 the division of rehabilitation of the National Committee of Mental Hygiene authorized a survey of the vocational rehabilitation services in the state hospitals of New York, Connecticut and Michigan. The findings were published in an enlightening summary by Rennie and others.[2] The authors expressed the opinion that many individuals could succesfully work even during periods of emotional or mental stress, and even that some persons who were actively psychotic could still be effective workers in the community. The vital need for vocational rehabilitation for certain patients was underlined by the authors, who believed that the self-confidence of some patients "had been so badly shattered" that they could not think constructively about their own rehabilitation until their self-confidence had been at least partially restored.

The Barden-LaFollette Act of 1943 provided that vocational rehabilitation may

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TABLE 1

Three years of vocational placement

REGION	NUMBER OF OF HOSPITALS REPORTING	NUMBER OF PATIENTS PLACED BY HOSPITAL	NUMBER OF PATIENTS PLACED BY STATE AND FEDERAL GOVERNMENT	TOTAL PATIENTS PLACED
1	12	161	38	199
2	16	110	179	289
3	43	443	890	1333
4	17	53	168	221
5	25	131	514	645
6	1	1425	000	1425
Total	114	2323	1789	4112

be given to those mental patients who need and can profit by these services. Rennie [3] estimated that 15% of those leaving the hospitals need and can profit by these services. In order to learn and report what the various state hospitals in the United States are now doing in the way of vocational rehabilitation, the writer sent a questionnaire to the 215 state hospitals listed by the National Institute of Mental Health, Bethesda, Md. The questionnaire solicited information about the number leaving the hospital in the last three years and the number who received vocational rehabilitation during this period. The questionnaire also inquired about planned vocational education in the hospital, about pay for patients, daywork and vocational testing. Comments were invited. A total of 114 replies were received (53%).

A few of those listed proved to be hospitals for sex offenders, for geriatric cases, for psychiatric patients who were also tuberculous, and for the criminally insane. Most of these were doing little or nothing in the way of vocational rehabilitation. However, there was one notable exception. The psychiatric division of a middlewestern penitentiary replied that during the last three years jobs had been found for 500 individuals leaving the institution and that courses in vocational orientation, commercial and various kinds of trade training had been provided. Planned vocational training was given to 400, or 63% of the population. The respondent remarked: "All inmates of the psychiatric division with the exception of senile and hospital patients are either in academic or vocational schools or are receiving training on the job under the supervision of vocational instructors."

VOCATIONAL PLACEMENT

Three years of vocational placement services are tabulated in Table 1. For convenience, the states were divided into regions: 1) New England, 2) North Atlantic, 3) middlewestern, 4) far western, 5) southern and 6 territories.

Forty-seven hospitals replied to two questions: "How many patients left your hos-

[3] Rennie, *op. cit.*

pital in the past three years by parole, discharge, extended visit, etc.?" and "How many patients received vocational placement during this period?" The one territorial hospital which responded to both questions had placed 83% (1,425 patients). However, most of the 47 hospitals answering both questions placed only 1% to 2% of those who left. Although this is far below the 15% postulated by Rennie as needing and being able to profit by vocational services, it is nevertheless a beginning in the right direction.

NEW PROGRAMS

Eighteen hospitals noted that new programs of vocational rehabilitation had been established recently. A Pennsylvania hospital replied that planned experiences for typists had been in operation for the last three months. With the help of volunteers, selected patients have been sent out to work during the day for social work agencies in the community. A hospital in Michigan has recently set up a sheltered workshop in which patients sew or knit one day a week for pay. A new rehabilitation unit has been established recently at a state hospital in the south. It provides diagnosis, guidance and physical restoration. The personnel for this unit includes a full-time secretary, a part-time rehabilitation worker, a psychologist and an occupational therapy worker.

Twenty-two hospitals reported that vocational counselors from the state bureaus of rehabilitation had been assigned to them recently. Three of these counselors work full-time at the hospital and the rest work one to three days a week.

PLANNED VOCATIONAL EDUCATION

The number of hospitals providing at least some planned vocational education is shown in Table 2.

Thus, 50 hospitals (49%) provided at least some planned vocational education. Forty-four of these indicated the number of patients receiving such education at the present time. The largest numbers reported were 475 patients at one of the territorial hospitals and 400 at a middle-western hospital. The median number was 15.

The types of training provided and the number of times reported are indicated in Table 3.

The following were listed once: librarian, hydrotherapist, chef, laundry, nurse's aide, shop mathematics, home nursing.

TABLE 2

Number of hospitals providing planned vocational education

REGION	NUMBER OF HOSPITALS REPLYING TO QUESTION	NUMBER OF HOSPITALS WITH PLANNED VOCATIONAL EDUCATION	PER CENT
1	11	7	64
2	17	6	35
3	36	18	50
4	14	9	64
5	24	10	42
Total	102	50	49

TABLE 3

Types and frequency of vocational training

TYPE OF TRAINING	NUMBER OF HOSPITALS REPORTING FOR THIS SERVICE
Vocational orientation	26
Commercial	23
Trade	19
Domestic science	17
Farming	10
Animal husbandry	7
Dairy	8
Beautician (beauty parlor)	2

Some hospitals had several different types of trade training. The following were listed: book-binding, printing, woodwork, photography, ceramics, weaving, carpentry, porter work, upholstering, blueprint reading, power machine sewing, plant maintenance, baking, tailoring, poultry raising, shoe repair, plumbing and mechanics.

In Massachusetts a newly organized Commission on Rehabilitation, after surveys of job openings in the community, noted that in spite of the then-current business recession stenographers and typists were at present in demand.[4] A training program for typists, accommodating 25 at a time, was established at a state hospital near one of the large cities.

According to the rehabilitation law, the division may provide a vocational instructor if the hospital provides space and equipment and makes a start on the training program.[5] In accordance with this provision, a state hospital in New Hampshire offers a series of business courses. They are taught by instructors from a neighboring business college. The hospital provides space, facilities and supplies while the State Division of Rehabilitation pays for the instructor.

Commercial courses are provided also by hospitals in Iowa, Nevada and California. Two years ago a hospital in Louisiana set up a mechanics trade school on the grounds of the hospital. A hospital in New York is now providing training for four selected patients in cooperation with the State Division of Rehabilitation. One is being trained in photography, another in business, a third as a nursery school teacher, and a fourth as an x-ray technician.

PAY FOR WORK AT THE HOSPITAL

Paying patients for their work is a controversial matter. It may be argued that the value of the work seldom or ever equals the cost of the patient's care. However, it seems possible that paying small sums to patients who are almost ready for parole would result in saving money for the state. In the various hospitals of New England men and women are now being employed to do work which patients might do for limited periods, such as porter work, housework, sewing, etc.

It is a question, also, whether the rehabilitation value of even small sums might not be great enough to more than pay for itself. Such pay might mean a restoration of a lost self-respect and sense of independence which are basic to any rehabilitation program. A system of pay for mental patients has been established in certain veterans' hospitals with notable success.[6]

Thirty-two (28%) of the hospitals stated that at least some patients were paid for

[4] Commissioner Francis Harding in an address to the Massachusetts Association for Retarded Children, at the Wrentham State School in May 1958.

[5] Rennie, *op. cit.*, 74.

[6] Peffer, Peter. "Money—A Rehabilitation Incentive for Mental Patients," *American Journal of Psychiatry*, 110(August 1953).

their services. About two-thirds of these made small token payments of 40¢ to $3.25 a week, sufficient to pay for small canteen supplies. The hospital with the largest percentage on the payroll was one of the territorial hospitals. This hospital pays 475 patients (39% of its population) $2 a week. A southern hospital has 1,100 patients (22%) on the payroll; it also pays $2 a week. Another southern hospital pays 50¢ a week to 14% of its population and a North Atlantic hospital pays 40¢ a week to 13%.

The institutions with the larger amounts of pay have only a few on the payroll. For example, a far western hospital which pays $15 a week has only six patients on the payroll. Likewise, a Massachusetts hospital paying $16 a week has only five patients on the payroll. The last annual report of this hospital states: "During the year we will continue to experiment with the new program of patient employment. Carefully selected patients will be put on the hospital payroll."

PAID DAY WORK

Outside day work may be regarded as a valuable device for bringing state hospital patients into contact with the community and as a feature of the new trend for lowering the barriers between inmate and citizen. Forty-three (38%) of the hospitals reported that at least some patients were now doing day work. A hospital in California has 100 patients on a day work schedule, and a hospital in Michigan permits such employment for 86 to 110 patients. These were the largest numbers reported. Two-thirds of the hospitals had fewer than 20 on a day work schedule, and a few noted that day work was allowed only in the summer.

The largest amount of pay was $14 a day; this was paid to 20 patients in a Texas hospital. Daily pay varied from 50¢ to $14, with a median at $4.75.

SHELTERED WORKSHOPS

Seventeen (15%) of the hospitals stated that sheltered workshops were available for selected parolees from their hospitals. About one-third of these were affiliated with the Goodwill Industries of neighboring cities. The types of work mentioned most frequently were light assembly work, woodwork, office work and hospital work. Pay varied from maintenance only to $27 a week.

VOCATIONAL TESTING

Sixty-one (53%) of the hospital said they gave vocational tests to patients, and several additional reported that patients were transported to the nearest state employment office for testing. The most frequently used test of intelligence was the Wechsler Adult Intelligence Scale, and of personality the Rorschach. The only vocational interest tests listed were the Strong Vocational Interest Test and the Kuder Preference. For vocational fitness, the General Aptitude Test Battery was mentioned three times.[7]

SUMMARY

Results of a survey of vocational services to state hospital patients in the United States have been reported. One hundred and fourteen replies (53%) were received.

During the last three years 4,112 recovered patients received aid in finding jobs. Typically, 1% to 2% of those leaving the hospitals received this service.

[7] This is a relatively new test of high range and validity and is available only at the state employment offices. See Donald Super, "The Multifactor Tests," *Personnel and Guidance Journal*, 36 (September 1957).

About half of the hospitals responding provided at least some vocational education. A few were providing such education for 400 to 500 patients. The median number was 15. The most frequently mentioned type of training was vocational orientation, next commercial, then trade.

Thirty-two (28%) of the hospitals stated that at least some patients were paid for their services. Typically, only small numbers are on the payroll, receiving 40¢ to $3.25 a week. However, a few have 400 to 1,100 patients on the payroll. A few pay $15 to $16 to small numbers of patients.

Forty-three (38%) of the hospitals reported that certain patients were now doing day work. Typically, the daily wage was $4.75, with less than 10 on the payroll. However, a few permitted day work for 80 to 110 patients.

Seventeen (15%) of the hospitals stated that sheltered workshops were associated with their hospitals, and 61 (53%) provided vocational testing.

About one-fifth of the hospitals noted that new rehabilitation services have been established recently with special state rehabilitation counselors working one to five days a week at the hospital.

Although the numbers of patients have been relatively small, about half of the hospitals responding were currently providing at least some vocational rehabilitation services. About one-fifth recently embarked upon new programs of vocational rehabilitation.

RONALD R. KOEGLER, M.D.

Chronic illness and the adolescent

The psychological effects of chronic illness can be devastating, and even relatively stable families are upset by such an occurrence to a family member. Realistic as well as emotional hardships result, with many individuals beside the patient affected. A great deal of time and effort of social agencies is regularly devoted to working with this problem.

Recent upheavals in our culture have further complicated the situation by bringing about complex changes in the family pattern. The decreased status of the father as head of the family, and a change in the recreational pattern with activities focused outside the home, are but two examples of influences which have lessened the ability of the family to provide support for its members.

A striking symptom of these changes is the dating pattern among adolescents, which is vastly different today from what it was twenty years ago. When commenting on "going steady" among adolescents, President Charles W. Cole of Amherst states: ". . . The new ways may also be related to the search for security. The boy or girl who has a steady is secure. Each partner knows that the other can be counted on for the coming high school dance or the next football game. In a day when the population moves from home to home with such freedom and when so many homes are broken by divorce or otherwise, this kind of security is very precious to young people. Perhaps, too, general decline of competition under the welfare state has led to less competitive social customs. Just as the retail stores have tried to shelter themselves from all price competition behind the so-called fair trade

Dr. Koegler, a research psychiatrist at UCLA Medical Center, presented this paper, in part, at the 4th annual social welfare institute held August 8, 1957 in San Diego.

laws, so our young people have divided into noncompeting twosomes." [1]

As President Cole suggests, behind these changes in the adolescent are changes in the family as a whole; the relationship between the members is much less strong and intense than it was thirty or forty years ago. Nowhere is the breakup of the family pattern more apparent than in its effect on the emotional security of the adolescent. "Going steady" and early marriage are a reflection of this basic feeling of insecurity, an effort to find in outsiders what they could not obtain in their own families.

This changing cultural pattern makes it more difficult for today's adolescent to adjust in a "healthy" way to illness. With the breakup of the family he feels less secure and has a greater need to belong, to have someone to lean on. Faced with illness, he has a greater tendency to become dependent and crippled by the illness, or else to deny any dependent feelings and refuse to accept the realities of his disease. Those working with these patients face an increasingly difficult task as more and more adolescents are seen who resemble this picture.

This is in addition to the "normal" confusion and restlessness of adolescence. Because of the very nature of adolescence, with the beginning of many adult feelings and responsibilities, a certain sense of anxiety and insecurity is almost usual. It is this insecurity which leads the adolescents to attempt to gain reassurance from their own age group, for example, or from those slightly older. They may despise those younger than themselves but they are afraid of those very much older than they are, and consequently seek reassurance and security among themselves. They may not like what the group or gang demands of them, but will go along with this in order to show that they can do what others do and that they deserve to be "accepted."

It is very easy to observe this in the sexual sphere. Adolescents are normally worried about their sexual role, and a reflection of this concern is seen by again using the dating pattern as an example. In the words of Lawrence Frank: "Dating appears to be a highly stylized form of interaction between teen-age boys and girls, in which they act and speak to each other primarily in terms of how their behavior will be rated by their own age group. Thus dating involves prestige, status, skill in a 'line,' approaches to intimacy and sexual provocation, but no consummation if the boy or girl is to maintain his or her standing. It produces constant anxiety and tension, frustration of any genuine emotion, and denial of spontaneous feelings and generosities. It persists as a self-created form of initiation ceremony (like that inflicted on adolescents in many cultures to test their readiness for and to signalize their entrance into adulthood). Dating is often highly disturbing and frustrating, even to the successful daters, and a source of endless unhappiness and acute anxiety to those who are not successful. It provides an occasion for release of sadistic impulses and for expression of masochistic needs, but it also often warps and destroys sexual functioning and needs." [2]

Traditionally the family was a means of support during this troubled period of adolescence. As the family crumbles in the Atomic Age, however, the normally anxious adolescent feels his sources of security—his parents—slipping from him. It

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[1] Cole, C. W., "American Youth Goes Monogamous," *Harper's* (March 1957), 29–33.

[2] Frank, L. K., "This Is the Adolescent," *Understanding the Child*, 18(June 1949), 65–69. (Available also as a reprint from the National Association for Mental Health.)

is easy to see why the current practice of "going steady" has evolved as a stopgap attempt to bring some security into their lives.

The adolescent has always been a difficult person to deal with when chronic illness strikes. An important reason for this difficulty is that the need for group approval, so characteristic of the adolescent, places a premium on being able to do whatever the other members of the group do, and those limited by illness are made acutely aware of their handicap. In effect, they are "different," and there is nothing more disturbing to the adolescent than to seem unlike the rest of the group—to be outside the group rather than inside. At the time in his life when he is most insecure he is unable to use the strongest defense against insecurity that the adolescent has—group approval.

It is extremely common for children to accept handicaps fairly well until the onset of adolescence, and only then show signs of emotional disturbance. Anxiety about the way their own body compares to others is a normal phenomenon in adolescence, and serves to bring into prominence any physical defects. Desperate attempts to erect defenses against this anxiety often result in neurotic decisions and actions. This is illustrated by the following case.

Johnny M was a 16-year-old Catholic boy who had a congenital heart defect (interventricular septal defect). This had not prevented him from being very active and his parents attempted to see that he had a "normal" life. He participated energetically in sports and was fairly expert in basketball and football. He tired more easily than his peers but responded to this by continuing to exert himself even though feeling greatly out of breath. In his own mind he denied that there was anything wrong with him, although he had been told by his parents that he did have some heart difficulty.

It wasn't until he was 13 and entering high school that trouble began. He went out for the football team and was turned down by the examining doctor on the basis of a "bad heart." It was after this that he became upset for the first time and seemed considerably depressed. He expressed a feeling that he would never get better and that it was useless for him to think about doing anything important later in his life.

Soon he began showing an interest in the priesthood and was encouraged in this by his parents. It was shortly after he had decided rather firmly that he would become a priest that he came to the UCLA Medical Center for an evaluation of his heart difficulty. It was felt that he would be an excellent candidate for surgery and when he was 14 a corrective surgical procedure was done, with the surgical expectation that his heart would then be perfectly normal.

Johnny had been rather pessimistic about the surgery and felt confirmed in this feeling when he did not feel much different afterwards. He went ahead with plans to enter a seminary as soon as possible in spite of some discouragement by his high school teachers, who felt that he was not ready scholastically.

Over the next two years he began to realize that his heart condition actually had improved and he was able to fully exert himself for the first time in his life. However, plans for the priesthood had gone ahead and at 16 he entered a seminary about 90 miles from home. From the first he had scholastic difficulties. Worried, he would go from one priest to another, asking about his grades and bothering them about how he was doing. The combina-

tion of the low grades and this anxiety reaction made them decide that he was not suitable for the seminary and he was transferred back to his high school.

Johnny accepted this dismissal fairly well and did not seem discouraged at all. He then announced that after he finished high school he would become a brother, one who, lacking the education of other members in the religious order, would do the menial work around the seminary.

When interviewed at this time he showed no anxiety, saying that his leaving the seminary was God's will. By thinking this way and applying it to other events which occurred to him, he was able to dismiss from his mind doubts and feelings of responsibility for his action. Psychological examination revealed gross feelings of inadequacy, both physical and emotional. Apparently he still viewed himself as a crippled individual, even though the operation had been successful and he appeared to be a healthy boy.

The family constellation gave some clues to his behavior. The father was of Irish extraction and remained distant from his children, similar to many other Irish fathers in the author's experience. Perhaps "unable to communicate" would be a better description of the father's problem with his children, but the result was that understanding between the boy and his father was minimal. The mother was of German stock and seemed to have a genuine interest in Johnny but little intuitive understanding of him. The family relationship was amicable but not close. All of his activities were centered outside the home—sports, school, entertainment.

DISCUSSION

Thus the situation became acute when Johnny entered his teens and could no longer avoid facing his physicial defect. It was apparently not possible to secure strength through identification with a weak, nonunderstanding father, and so he sought a stronger father-figure in the church. This was a neurotic decision, and he was not prepared intellectually or emotionally for the seminary life.

Realistically he is sound of body, but unconsciously he still regards himself as inadequate. One can anticipate emotional difficulties in the future for this boy.

Johnny illustrates the lifelong psychological problem frequently brought on by chronic illness. It occurred even though the physical disability was effectively removed. Perhaps this indicates that such corrective operations should be done before adolescence, if possible, in order to avoid permanent distortion of the body image. Present-day families are frequently unable to fill their traditional role and provide support for the sick child.

SUMMARY

Emotional reactions to chronic illness frequently become manifest or accentuated with the onset of adolescence, related to the normal adolescent preoccupation with the body image. Recent changes in the cultural family pattern, with weaker family ties and supports, have accentuated this problem and must be taken into account in casework and psychotherapy. It is also suggested that corrective surgical procedures be performed before adolescence when this is feasible.

DANIEL I. MALAMUD, PH.D.

Educating adults in self-understanding

In recent years we have witnessed a rapidly growing interest in the promotion of mental health in the population at large, and as this movement gains momentum we may expect that increasing attention will be paid to the challenge of devising methods for furthering self-understanding in groups of relatively normal persons (2, 3, 7). For the last 12 years I have been deeply involved with this very problem at New York University's division of general education where I teach noncredit courses in self-understanding for adults. The first course is entitled Workshop in Self-Understanding. Two additional workshops are provided for students who wish to continue on an advanced level. My teaching methods have evolved in the course of classroom experiences with groups of adolescent army recruits (1), nursing and medical students, labor union members and executive secretaries (8). In the present paper I shall summarize my workshop approach at New York University, centering mainly on those planned procedures which I have found most useful in the first course.

A workshop meets once a week for 15 weeks; each session lasts an hour and three quarters. While the first workshop is open to any adult who wishes to register for it, a previous course in psychology is a prerequisite for the advanced workshop, and the workshop in self-exploration (the most advanced of the three courses) requires my permission for admission. The adults who attend these courses vary widely in age, education and socioeconomic background, with both sexes well represented.

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Over 60 students usually register for the first workshop, and about 20 to 30 for each of the advanced workshops. (I was flabbergasted at first at the prospect of working with such large groups, but I have come to learn that the size of a class does not bear any necessary one-to-one relationship to its cohesiveness, emotional involvement or rate of progress; much depends on what the group does together, on my relationship to the group and on the kind of atmosphere we can establish together.)

The majority of the students appear to be relatively normal men and women who function adequately—even with considerable self-satisfaction—in many life areas, yet who desire help in understanding themselves. Puzzled by contradictions in some of their feelings and actions, many of them seem to be groping for a sharper definition of their identity and an extended awareness of why and how they have become the kinds of persons they are. Some, on the other hand, appear to be motivated more by the hope that they will acquire "prescriptions" for personal problems or techniques for influencing others than by an interest in achieving a deeper self-awareness. More detailed definitions of the different motivational patterns with which students come to class, the relative frequencies of these patterns and how they relate to outcome will need to be determined by future research.

GENERAL APPROACH

My central aim in the first workshop is to sharpen the student's awareness of one basic fact—namely, that unconscious, inner forces play a part in governing his everyday behavior. The student's spontaneous experiences in the classroom can be most convincing illustrations of this fact, provided that he learns how to attend to these experiences, becomes sensitized to noting their repetitive patterns, and gains skill in exploring their underlying significance. I try to "arrange" such learning experiences by introducing planned group procedures of a provocative nature which engage the student's personal involvement in exploring the meaning of his reactions. I am also quick to capitalize on unforeseen classroom occurrences which show promise of stimulating useful discussion—for example, an angry dispute between two students.

Instead of serving as an authority who gives the "answers," I encourage members to act as participant-observers, to become attentive to the interplay of events in the classroom, and to observe themselves as they participate in these events. I aim especially at sensitizing the student to his feelings; while these provide vital clues to understanding his unique needs and wishes, he is often either unaware of just what he is feeling or unable to differentiate clearly one feeling from another.

When questions are directed to me in the early sessions I usually turn them back to the group. I do not hesitate to leave a question up in the air and move on to the next nor do I make any effort to leave the class with a neat summary at the end of a session. As the group begins to take more active responsibility for exploring issues that arise in class I gradually assume a more active role in the give and take of discussion. I underscore insightful comments, offer my opinions and observations, and correct serious misstatements of fact.

I encourage frank and open communication in the group by setting an example of such communication myself, by sharing with the group both my past experiences and my on-the-spot reactions. For example, when I invite the group to explore its first childhood memories I start the ball rolling

by submitting my own first childhood memory to the group for analysis. When I am anxious, pleased or irritated I try to share these feelings with the members if it seems useful to do so. I also set an example for the rest of the group in my curiosity about the commonplace, cautiousness about jumping to conclusions, and readiness to admit mistakes.

In order to progress in the workshop, members need to think out answers to their own questions, share thoughts and feelings which they ordinarily keep to themselves, and examine critically their habitual ways of thinking and feeling. It is not surprising that students experience some form of resistance in regard to fulfilling one or another of these requirements, but when such resistances are focused on directly and when the factors which underlie them are recognized and explored, what gradually develops is a most meaningful kind of learning. Examples of methods for helping a class to work through its resistances have been described elsewhere (5) and will therefore be given little attention here.

I request each student to mail to me after every session a one-page letter in which he reports his reactions to what transpired. I write out comments and questions in the margins of these letters and then return them to the group at the beginning of the following week's session. Each week the members mail in both the previous week's annotated letters and their new letters. In my written annotations I suggest new lines of exploration, give reassurance and encouragement when necessary, and correct any misunderstandings. These letters provide the individualized attention for which most students feel a strong need, help me to keep in close touch with new developments in both the group and in individual members, and enable me to deal with anxieties and misconceptions very soon after they occur. Letters also provide invaluable data for studying the dynamics of the workshop process.

Probably all students experience some anxiety during the course. This is only natural and to be expected. In mild degree, anxiety serves as a constructive force in the learning process, shaking student's complacency about what has hitherto been taken for granted and spurring them on in their search for greater clarity about themselves. An excessive degree of anxiety rarely seems to develop. Students have at their unconscious command a variety of automatic mechanisms for warding off the impact of events that they are not ready to assimilate. In addition, the following safeguards and opportunities for extending reassurance have become a built-in part of the workshop process:

- Students are forewarned about the confusion, frustration and resistance they are likely to experience in the course. They are also cautioned against jumping to premature conclusions about themselves. I give frequent recognition to members' strengths and positive qualities, and I encourage students to view their shortcomings as inevitable outcomes of their life experiences rather than simply as faults to feel guilty about. I make free use of humor, especially in situations that threaten to become too "heavy."

- The introduction of films and other stimulus situations is carefully timed to fit the apparent readiness of the group. The student's right not to learn is respected, and I try to avoid pressuring anyone to move at a faster pace than he seems ready for. I emphasize that no one is required to speak in class and that many students learn as much by listening

thoughtfully as others do by taking an active part in discussion.

• In the course of exploring classroom events, students often report relevant personal experiences, and such reports are welcomed, but I discourage any extended discussion of an individual's current personal problems by pointing out the obvious limitations of the classroom situation for dealing with them. We center on the difficulties the group shares in the here-and-now classroom situation rather than on those that individual students have outside of class.

• I set aside the last ten minutes of each session for the airing of any hitherto unexpressed feelings and thoughts, and during this period I take the opportunity to give reassurance when necessary or to correct serious misconceptions. I also make myself available for a few minutes before and after each class period for any student who may wish to discuss his reactions to a session with me privately.

PLANNED GROUP PROCEDURES

I have developed a large repertoire of group "experiments" and other planned procedures designed to excite the members' curiosity about aspects of their behavior which they have hitherto taken for granted or considered insignificant. These methods involve the group in simple here-and-now experiences which are accessible to conscious exploration, elicit sharp individual differences in response and provoke students to search out for themselves the significance of these differences. Most planned procedures are designed to illuminate one or another of the following interrelated areas: individual differences, interpersonal relations and the role of childhood experiences in personality development. Examples of procedures in each of these areas will be summarized below. It will be obvious to the reader that these procedures are not finished products which can be applied in a mechanical fashion. The basic elements of each method often need to be varied appropriately in different group situations, but these variations will not be considered here.

INDIVIDUAL DIFFERENCES

Throughout the course I focus attention on how differently members react to the same situation and how these differences may reflect their varying orientations towards life. Confronted by reactions strikingly different from their own, many students cannot help but wonder whether their responses are as inevitable and as objective as they had assumed. They begin to examine their perceptions and judgments more critically, and gradually become aware of the many subjective factors which may enter into their reactions.

Mental health films which dramatize life stories are very useful for bringing out individual differences. Instead of postponing discussion until after a film is over, I stop the film at appropriate points and discuss scenes on the spot, asking members how they feel about each character, encouraging them to predict how characters will behave in later scenes, and inquiring as to what events in the movie scene remind them of what goes on in the workshop. In response to these queries, dramatic individual differences usually make their appearance and are examined in discussion.

Confronting the group with a crisis-in-miniature also elicits sharp individual differences. For example, at my request, three women students role-play in turn the part of a mother who tries to get her five-year-old son to stop his play and come in to dinner. With each of the volunteer mothers separately, I play the part of the

son, who after a minute or two of irritable resistance to his mother's pressure bursts out, to each "mother's" real surprise, "Oh, why don't you drop dead, you old witch, and never bother me anymore!" Most members split sharply in their reactions to this outburst, some identifying with the child, some with the "mother"; some believe that the child really meant "drop dead," while others are strongly convinced that no five-year-old could really mean "such a terrible thing."

Several procedures have a playful, gamelike quality and yet can be effective in stimulating sober self-questioning. In one session, upon request, each member brings in a balloon. I inquire how they went about obtaining their balloons. Some report they themselves bought the balloons. Others asked friends to buy the balloon for them. Still others come to class without any balloon, confident that another student will have an extra one, and indeed some students do bring extra balloons! After discussing the possible implications of these individual differences, I suggest that they blow up their balloons and then report what inner experiences they had as they engaged in this task. A number of students feel "exhilarated"; others feel "silly and embarrassed." Some fear they will be inadequate to the task, while others fear they will "go too far" and break the balloon! Following the group's analysis of these differences I request the members to rub their blown-up balloons gently against their faces, keeping their eyes closed as they do so, and to "permit" some image to pop into mind. The reported images range from those which are frankly sensual and involve human beings to those which are abstract and impersonal. The possible factors underlying these differences are explored. My final instruction to the group is to break the balloons. As one would expect, members break their balloons in quite different ways and vary markedly in their degree of inhibition about engaging in this destructive act.

I strive to sensitize students to differences in the nonverbal aspects of their behavior and how these too express their varying styles of life. For example, I direct attention to their choice of seats in the classroom, and I question whether their consistent choice of certain seats might reflect general life attitudes. After some discussion of this, I ask all members to change their seats, to find a seating position as different as possible from their usual one, and to observe their own and each other's behavior as they go about this task.

Individual differences in response to the workshop experience itself are explored in many ways, one of the most fruitful being through the medium of dreams: I ask all members to dream about the workshop on a given night and to bring their dreams in for group analysis. Details of the procedure that I follow in the session devoted to dreams and examples of such workshop dreams have been reported elsewhere (5).

INTERPERSONAL RELATIONS

Through an examination of their relationships to each other and to me, students can learn about the unverbalized assumptions they make about others and the interpersonal techniques they employ habitually to meet emotional needs and avoid anxiety. Competitiveness, fearful withdrawal, aloof superiority and efforts at gaining approval are among the common relationship patterns exhibited in the classroom, providing many rich opportunities for learning how one's actions affect others and vice versa. Exploration in this area, however, proceeds very gently and gradually, and is

more heavily emphasized in the advanced workshops.

I have found the following series of tasks useful both as a rapid means of acquainting members with each other (especially in helping them to identify each other by name) and as an intriguing introduction to interpersonal dynamics: I ask each person in the group to give in turn his first name and to tell us about a "favorite something" from childhood—a person, a book, an activity, or whatever. After discussing what they noticed about themselves and each other as they went about this task, I ask the members to write down as many of the first names in the group as they can recall. Students vary markedly in the number of names recalled, and we discuss what factors, other than sheer memory capacity, might account for this range of differences. When I inquire how they went about trying to recall names, some individuals report that they proceeded systematically by writing down the name of the first student in the first row, then the second student's name, and so on, while others state that they wrote names down as they popped spontaneously into mind. We explore what different personality factors these contrasting approaches might reflect.

I then ask those persons who recalled names spontaneously to read off the first three names that came to mind, and to consider whether these names may have had some special significance for them. After looking into this possibility with the group I ask each member to close his eyes and repeat his name to himself, noticing what thoughts, feelings or images occur. Many students are startled at the negative or positive associations which come to them; these are reported and discussed. Finally I instruct members to call for those names they still cannot recall. After this instruction has been followed I wonder out loud why students found this or that person's name difficult to recall, and we explore what personal reactions to particular members or what emotional reactions to their names may have led to the memory blocks.

I often ask the group to report its observations of me. At first students are quite inhibited about making such reports, and after I point this out we go into the fears which block them. Gradually gaining courage, they begin to express what they notice about me, almost invariably touching off some productive discussion. (One student, for example, observes that I smoke a lot and wonders why. The class bursts out laughing, and I join in the laughter. I tell the student that smoking relieves the tension I experience in standing up before a group. I then suggest that the group's laughter reflected sudden anxiety, and we explore what might have prompted this development, before long discussing their "need to put authorities on pedestals, and also to knock them off.")

I present "Facing Reality," a film deliberately chosen for its superficial quality. When I ask the group for its reactions to the film, various favorable comments are made about it. I then tell the members that I think the film "stinks," give my reasons, and inquire whether others had similar reactions. Some members now admit that they had similar critical thoughts. In the discussion which follows we explore why these students felt inhibited about expressing their reactions earlier, their fears of "criticizing a film chosen by the instructor," and their conflicting attitudes towards authority.

Various procedures are designed to confront the student with the impression he makes upon others as well as to encourage

him to explore what inner factors determine his varying emotional reactions to different members of the group. The following "experiment" was inspired by Kelly's "Role Construct Repertory Test" (4): I request three students who are interested in learning what impression the group has of them to volunteer to be subjects. I then ask the group to judge in what ways two of the three volunteers are alike and different from the third. A number of members then give their impressions, some noting a resemblance in one pair of the trio, others in another pair. At my suggestion their categories take the form of images whenever possible. (For example, "Bert and Lenny are like volcanoes that explode, whereas Irving is like a volcano that just rumbles underneath.") After the group has made its "sortings" of the trio, I ask the three volunteers to give their reactions to the group's categorizations. After repeating this procedure with several volunteer trios I ask the students to consider whether the categories they used in judging others may reflect aspects of themselves.

I often read to the class (without identifying the authors) carefully selected excerpts from students' letters; these excerpts may refer to critical class events or to significant expressions of feelings about me or others in the group. (The students are informed at the beginning of the course that such readings may occur.) After reading a series of such excerpts from different students I ask the class to give its reactions and comments. In the discussion which follows, students whose letters were read may preserve or discard their anonymity, as they wish. The timely introduction of students' letters in this way often enables a group to explore interpersonal undercurrents which might otherwise never be brought to the fore.

ROLE OF CHILDHOOD EXPERIENCES IN PERSONALITY DEVELOPMENT

In the course of discussing their individual differences and interpersonal relations I encourage students to speculate about the kinds of childhood experiences which may have predisposed them to react as they do. I also introduce various procedures specifically designed to focus the group's interest on the formative influences in childhood.

Films such as "Angry Boy," "Lonely Night" and "Overdependency" are excellent portrayals of the effects of childhood experiences upon personality development. The usefulness of these films is enhanced if, before they are presented, the class is involved in some dramatic way in a consideration of the central issues raised by the film. For example, prior to the showing of the film "Feeling of Rejection," dealing with the conflicts generated by Margaret's compulsive need to comply with the wishes of others, I ask the group to write out completions to the following sentences: "Mother liked me best when I . . ." "People like me best when I . . ." "I like myself best when I . . ." I collect the members' papers, read a number of them aloud, and discuss with the group the implications of each set of completions.

The Adlerian emphasis on the value of first childhood memories inspired the following procedure: I pass out paper to the group and ask each member to write out his very first memory. I then introduce the notion that first memories may reflect basic attitudes (both past and present) towards ourselves and others. I relate some sample first memories to the group, and we speculate freely about what these memories imply, with the understanding that our speculations are only possible hypotheses. When students show that they have caught on to some of the suggestive

clues contained in memories I ask them to examine their own recollections and to write interpretations of them on the other side of their sheets. I then collect the papers and choose one to read to the group without mentioning whose memory it is. After the group gives its reactions I turn the memory over to the other side and read the student's own interpretation. I then invite the individual whose memory it is to give his reactions to the group's speculations. This procedure is then repeated with the memories of as many other students as possible.

The following procedure has been useful in stimulating personalized discussions of the mother-child relationship: I request members to close their eyes and to hear their mothers' voices as they heard them in childhood. After a few moments I ask them to open their eyes and to report what they observed in themselves as they went about this task, what they heard the mother say, her tone of voice, and the surrounding situation. The members note how different these "heard" statements are and go on to explore what these differences might suggest about the meaning of the mother-child relationship for different participants.

The following procedure was suggested by Alfred Adler's emphasis on the significance of birth order: After presenting the film "Sibling Relations and Personality" I break up the group into subgroups according to birth order (oldest children in one group, youngest in another, middles in still another and "onlies" in a fourth group) and request the members of each subgroup to explore what kinds of experiences they had in common as a result of being the oldest, the youngest, etc., and how these experiences influenced their later development. Thirty minutes later I call the subgroups together to present their findings for general discussion. At some appropriate point I ask the members if they can trace any relationships between their birth orders and their behavior in the workshop.

I devote one session to an analysis of members' photographs of themselves as children: I ask each student to bring in three photographs of himself as a child below the age of six, pictures in which he appears with parents or other persons. Each set of photographs is projected one at a time onto a large screen so that the group can study together the child's stance, facial expression, degree and kind of physical closeness with others in the photograph, and other physical clues. The group, usually unaware of the photographed subject's identity, gives its impressions of the child's personality, the problems he may have faced as a child, and how he might have attempted to cope with them. Finally, the individual whose photographs were presented gives his reactions to the group's speculations.

FUTURE PROSPECTS

A majority of students report in written evaluations at the end of the course that their eyes have been opened to the meaning of some of their own behavior, and to that of others close to them. They describe specific changes "for the better" in their self-attitudes and in their interpersonal relations. They claim to have become more self-questioning, more alert to manifestations of the unconscious, and more aware of the complexity of human behavior. At the end of almost every workshop one or two members report that they have developed incentive or sufficient courage to seek psychotherapy for themselves.

These reports of my students and my own classroom observations have been encouraging indeed, but such criteria are too limited to provide more than impression-

istic answers to such questions as the following: What is the scope, depth and permanence of changes which take place in students, and to what extent are these changes attributable to the workshop? How do these changes come about in different students, and why do some students experience little or no change? How can the dynamics of the workshop process best be described? What role do the following factors play in this process: group composition, the instructor's personality and approach, the content and sequence of planned procedures, and crucial events unique to each group? Obviously, the future development of the workshop will require detailed descriptions of the teaching-learning process, the testing of hypotheses in controlled experimental studies, and the creative exploration of new group procedures.

My experiences with the workshop to date suggest that it can make a significant contribution to mental health education for the adult community. There are multitudes of relatively normal persons with mild emotional problems who desire help in understanding themselves as a means of increasing their capacity to enjoy life. Where can they turn for the kind of self-enlightenment they require? Magazine articles, books and lectures are sometimes helpful, but more often than not they represent sterile intellectual experiences in which new terms and concepts are absorbed in an abstract way without the kind of personalized impact which stimulates growth on an emotional as well as a cerebral level. While psychotherapy might be a very beneficial procedure for gaining such growth it is doubtful indeed whether most people would be willing, or for that matter need, to undergo so intensive a process in order to achieve a significant extension of self-awareness. Besides, the severe shortage of psychotherapists makes it obvious that psychotherapy is, and probably always will be, out of reach for most of the population.

The potential value of the workshop in this neglected area of need thus seems obvious, especially when one considers that relatively large groups can be reached by this approach with a minimum of time and manpower.

My interest has recently been attracted to the possible clinical applications of the workshop. It is not unusual for clinic outpatients to wait many months before they can begin psychotherapy, and even after it is begun many patients find the treatment process so strange and unexpected that they often require many additional months before they learn how to collaborate productively with their therapists. With these considerations in mind I have conducted thus far five workshops with outpatients on waiting lists prior to their entrance into psychotherapy—three at the Kings County Hospital Mental Health Center and two at the Alfred Adler Consultation Center. These clinic workshops have varied in size from 18 to 30 members. Most of the participants were diagnosed as neurotics or character disorders. Although the outcomes of these pilot studies are still being evaluated, it would appear that the workshop method can be effective in generating self-insights and a degree of symptomatic relief, in overcoming resistance to group therapy, and in preparing patients for their collaborative role in treatment (6). (A mental health project grant from the National Institute of Mental Health is enabling further exploration in this area.)

The workshop could also be a useful training course for students of clinical psychology, social work and teaching. By comparing his reactions with those of others responding to the same workshop events, the trainee attending such a course

could sharpen his powers of observation, become more aware of the biases which influence his reactions, and increase his skill in assessing interpersonal events in which he himself is involved. In addition, the workshop experience could serve as a bridge between theory and practice, providing the trainee with real life opportunities to test out his understanding of psychodynamic concepts as he strives to explain and predict classroom events.

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Book Reviews

STUDYING THE INDIVIDUAL PUPIL

By Verna White

New York, Harper & Brothers, 1958. 238 pp.

Emotional factors significant in mental health are emphasized in this book by Dr. White. Some of the more frequent indications of the emotional problems of school children are, she says, "daydreaming, nailbiting, sullenness, kicking, swearing, telling untruths, stealing, bullying, and resentment toward authority." She warns, however, against misinterpreting certain kinds of emotional outbursts and "crying produced by frustration," which may, she says, be regarded as normal in the young child if the signs are not too intense and are not constantly manifest.

Basic in Dr. White's presentation is a specific point of view as to the primary objective of education today in the United States—that it is "to assist children to a happier, more satisfying life." This obviously involves a great deal of knowledge by the teacher of the children she has in her care. Measuring academic growth by means of standardized tests is not sufficient today, Dr. White says. "The teacher must attempt to gain answers to a series of questions for each pupil as the children enter the classroom," she asserts. What goals and aspirations does the child have? How acceptable are these goals and his means of attaining them? What aspirations do his parents have for him? How consistent are the problems he is contending with at home and in his social life? What are his needs and resources?

The author admits that there are no standardized methods of answering such questions as these, but in a final chapter she does set forth the competencies necessary for studying the individual pupil and what this means in assisting children to a happier, more satisfying life.—W. CARSON RYAN, Chapel Hill.

EMOTIONAL DYNAMICS AND GROUP CULTURE

By Dorothy Stock and Herbert A. Thelen

New York, New York University Press, 1958. 296 pp.

This monograph with an impressive title is subtitled "Experimental Studies of Individual and Group Behavior." It is the result of some five years of research into group operation by two investigators from the University of Chicago working from the National Training Laboratories (a section of the division of adult education service of the National Education Association). The aim was to contribute to the theoretical and practical understanding of the effects and control of social, emotional and psychological factors in group situations. Obviously, such research would be of value to educators, sociologists, the military service, industry and students of groups. They will find this monograph interesting, if they are technically equipped to plow through it.

The research is based on the concepts of W. R. Bion, who has written extensively upon the relationships in groups between work and emotional states, devised categories of emotionality, developed concepts of valence and of group culture or process. Valence is the individual's capacity for instantaneous combination with another for sharing and acting on a basic assumption. The group was to be studied as an organism.

A great deal of work and thought obviously have gone into this rather dry, academic monograph. If one is well equipped in his knowledge of statistics and educa-

tional theory, I'm sure this book would be easier to read. For the usual psychiatrist, even if he is interested in group practices, it is heavy going. One section which may be of some clinical interest attempts to translate into practical terms the major implications of the work on groups as social instruments. Problems such as the importance of group composition and size, what is required for maximum creativity in the group, whether a group needs a designated leader, whether there is any best leadership style, and whether member satisfaction is a sign all is going well, are discussed.

The discussion is stimulating but contains little or nothing that hasn't been written about before. It is important to document and research but in this instance I closed the book with the feeling that the mountain labored and brought forth a mouse. The psychiatrist can find more provocative, pertinent material on groups and probably the other disciplines also can.—JOSEPH D. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

CLOSED RANKS: AN EXPERIMENT IN MENTAL HEALTH EDUCATION

By Elaine Cumming and John Cumming

Cambridge, Harvard University Press, 1957. 192 pp.

One of the first carefully controlled field experiments in attempting to change a community's attitude toward mental illness is documented in detail in this book. The experiment was something of a failure, and why and how this happened makes both interesting and instructive reading.

The community had not actively sought a mental health education program. Those who supervised the project, Elaine and John Cumming, sociologist and psychiatrist respectively, who also are the authors of this book, were not connected with a local agency and therefore had no appropriate community base from which to operate. Unhappily, this effort at public education fostered not only resistance but actual hostility as well. By the time the project had ended, the gulf between the mentally healthy and the mentally ill had widened considerably. The population appeared to "close ranks," only too happy to push aside the mentally ill and forget about them.

In retrospect, the authors seriously question some of their original planning and the methods by which they were carried out. The fact that little had previously been done to chart the effectiveness of mental health education made the Cummings' original task all the harder, and they frankly discuss many of the pitfalls encountered.

The book is divided into three parts. Part 1 describes the character of the community, the kind of educational effort that was made and the general reaction to it. Part 2 gives in detail the methodology of the survey and statistical findings. In Part 3 the content is theoretical, analyzing those factors which went into the makeup of the study. The entire program, from the first survey of attitudes through the educational attempts and re-evaluation of the community feeling, is described clearly and concisely.

Many thoughtful implications can be drawn from the experiences delineated in this book, particularly as regards the social gulf between the mentally ill and the rest of the population and how this can affect the health of the community and the rehabilitation of those who are sick. Some aspects of the Cummings' experience were positive, such as the disclosure that public understanding can be increased, despite the admitted failure of the over-all project to reach its goals. Anyone concerned with the planning and carrying-out of community

programs, as well as persons who work with the mentally ill and their families, will find the book of extreme interest and help.—VICTOR BALABAN, ED.D., National Association for Mental Health.

ALCOHOL AND THE JEWS

By Charles R. Snyder

Glencoe, Ill., Free Press, 1958. 226 pp.

The fact that the drinking practices of the Jews differs from those of other groups makes a scrutiny of Jewish drinking habits and the dynamic reasons for this difference of great interest to all who are concerned with the problem of alcoholism. The author has conducted a careful study of 73 Jewish men in New Haven, using the interview technique and supplementing it with data from questionnaires administered to 644 male Jewish college students. The latter are compared with Protestant and Catholic students. In considering the patterns, the roles of the ceremonial orthodoxy, regional background, generation, class and ingroup-outgroup relations are evaluated. Similar findings emerged in the two groups of Jews, using both techniques.

The author concludes that drinking pathology cannot be explained exclusively by individual psychology or by a craving for alcohol presumed to be physiologically determined but needs to be related to cultural traditions regarding drinking. He finds that where drinking is an integral part of the socialization process, is interrelated with the central moral symbolism and is practiced in the rites of a group, the phenomenon of alcoholism is conspicuous by its absence and sobriety can be sustained even though drinking is extensive. On the contrary, alcoholism may be expected to increase when there is disruption of traditional patterns in which drinking is integrated, when there is dissociation of drinking from the normal process of socialization and moral values, and where alcohol is used for purely individual purposes.

This report is of interest not only because of its intrinsic value but also because of the light it throws on the sociocultural approach to the study of drinking and other forms of behavior.—HERBERT S. RIPLEY, M.D., University of Washington.

MASTER YOUR TENSIONS AND ENJOY LIVING AGAIN

By George S. Stevenson, M.D. and Harry Milt.

Englewood Cliffs, N. J. Prentice-Hall, Inc. 1959. 241 pp.

This is a book about how to apply mental health principles to daily living, written for the average citizen by the man who is the foremost authority on mental health in our country, Dr. George S. Stevenson, in collaboration with his co-worker at the National Association for Mental Health, Harry Milt. That there is a public eager for its content has been made clear by the interest more than a million readers have shown in the authors' booklet, "How To Deal With Your Tensions", the precursor of this larger work.

Its purpose is to help men and women, regardless of differences of educational background, to understand how psychological tension operates—that they may take a fresh look at their own lives and be moved to act for their own improved mental health.

Beginning with an introductory picture of "This 'Shook-up' Age" and its hazards, the contents are divided into three parts.

Part I describes the origins of tension, shows its relationship to anxiety, and raises questions about how we may recognize excessive tension in our lives. Part II discusses eight methods of action for getting rid of tension. All of these involve feasible forms of either physical or deliberative action, such as talking it out, getting away for a change of perspective, and dealing with one problem at a time.

Part III considers ways to avoid tension-building situations in bringing up one's children, appraising one's job, and living with one's marriage partner. This portion is done especially well, with a naturalness that avoids ponderous psychological overtones.

The difficult task of writing a popular "how to do it" book in the intricate, many layered area of personality could have been mastered so successfully only by a psychiatrist and psychologist sufficiently sure-footed in their professional grounding, as are these authors, to be able to convey accurately psychological meanings with simplicity and ease. This book's writing is in clear, unpretentious language, buoyantly close to the popular idiom. It contains many illustrations of human beings living through familiar every-day situations.

The level of this book is mass education. In offering cues for self-help, the authors carefully indicate differences in degree of problems, pointing out situations in which readers may require help from qualified specialists. For the reading public the important thing is that this popular and excitingly written book is psychologically sound. It neither goads persons to strive for high levels of functioning they cannot maintain; nor does it overwhelm them with professional data they do not require. It does what it can to teach the feasible. EVELYN D. ADLERBLUM, School of Education, New York University.

PERSONAL, IMPERSONAL AND INTERPERSONAL RELATIONS

A Guide for Nurses

By Genevieve Burton

New York, Springer Publishing Company, 1958. 230 pp.

The student who takes advantage of the best that is currently offered in nursing education is given help in recognizing the interpersonal elements involved in a variety of clinical practice situations. Throughout the period of her college training she becomes increasingly well grounded in personality theory and in psychopathology. Under the guidance of her instructors she makes a careful study of interaction variously including patients, their families, herself and other personnel. Her observations are made not only in general and psychiatric hospitals but also in homes, schools and a number of different health agencies.

This book is intended primarily for practicing nurses who have not been so privileged as students and who may not be particularly motivated to serious study. Using simple language and many examples drawn from actual nursing situations, the author throws light upon a substantial number of interpersonal problems that nurses are likely to encounter in general hospital practice.

Emphasis is placed throughout the book on the nurse's need to recognize and accept individual differences in behavior, especially in expressions of feeling. The counseling role of the nurse is delineated without the use of technical terms, and again with illustrative anecdotes. The nurse is not neglected as a person in her own right. Motivations and attitudes commonly underlying the behavior of nurses become the focus of attention in a separate chapter as well as in other parts of the text.

By using them as basic to the structure of the book, Dr. Burton covers most of the topics included in the usual elementary course in personality development: psychosexual organization, socialization, conflict, anxiety, adjustment and the mechanisms of defense. The book's unique value, however, lies in the aptness and color of the many anecdotes it contains and the adroitness with which the author uses them to interpret theoretical concepts. One unforgettable narrative, the story of Danny and the croupette, which is used to illustrate (and incidentally to refute the concept of regression as an inevitable concomitant of illness) has all of the elements of high tragedy.—KATHLEEN BLACK, National League for Nursing.

GROUP PROCESSES

Transactions of the 3rd Conference
of the Josiah Macy, Jr. Foundation
October 7–10, 1956

Edited by Bertram Schaffner

New York, Josiah Macy, Jr. Foundation, 1957. 328 pp.

This is a carefully edited transcript of a Macy conference on "persuasion." To appreciate fully the richness of this material, the reader will need to be fairly well-oriented in the behavioral sciences. People with this background and a basic interest in human relations research will almost certainly be fascinated by it.

The title of the book is, in a sense, misleading. The "group processes" with which it deals most directly are interpersonal relationships. Group pressures and other forms of milieu control are examined from the standpoint of their effect upon individuals but not as factors in any kind of total group development.

The foreword by Frank Fremont-Smith, medical director of the Josiah Macy, Jr. Foundation, explains the purpose and nature of Macy conferences in general. The goal of this conference program is stated as "the promotion of (interprofessional and interdisciplinary) communication, the exchange of ideas, and the stimulation of creativity among the participants." Following the foreword is a lively series of autobiographical sketches introducing the members of the group, each a distinguished scientist in his own field.

Then comes the heart of the matter, in 4 chapters each containing a brief report of a piece of signficant research and the discussion pertaining to it which took place in the meeting. Chapter headings are Interpersonal Influences within the Family, Interpersonal Persuasion (in a mental hospital), Further Studies on Maternal-Neonate Interrelationships, and Chinese Communist Thought Reform.

John Spiegel makes the first presentation, an episode from an interdisciplinary study that he and Florence Kluckhohn are conducting at Harvard on "the effects of conflicts between cultural value-orientations on the processes of interaction within a family and, consequently, on the development of healthy or pathological processes within members of the family." The protagonists in this incident are an Irish-American mother and a 16-year-daughter who is late coming home from a dance. Analysis of the interaction between these two reveals the extreme complexity of the situation: the conscious and unconscious motivation involved, the complementary structuring and restructuring of roles, the elements in the conflict (discrepancy) between the two personalities, the issues to be faced in the handling of the differences. Excerpts from records of two other cases in the study deepen the discussion.

This chapter is an excellent introduction to the second in which Erving Goffman, then with the National Institute of Mental Health, presents findings from his study of what went on in a state mental hospital between the patient and the institution as the latter attempted "radical resetting of the self-regulative mechanisms of the individual" (inmate). This section might well be required reading for professional staff in mental hospitals everywhere in this country. More research of this kind should help us all to find our blind spots.

The discussion in the third chapter is based on a film study of patterns of interrelationships between human mother and baby as the infant learns to nurse. In this and in related animal studies "persuasion" is defined as "potentiality for behavior which . . . draws forth biologically appropriate responses from other members of its population." The reporter here is Helen Blauvelt, who draws carefully upon biological studies of animal and human newborn now under way at Howard Liddell's behavior farm laboratory at Cornell and in Julius Richmond's department of pediatrics at the New York State College of Medicine in Syracuse.

In the fourth chapter, Robert J. Lifton of the department of psychiatry of the Harvard Medical School discusses the study of Chinese Communist thought reform that he carried on in Hong Kong from February 1954 to June 1955. Here, surely, is "persuasion" in its purest, most awful form! The self-defeating tactics of the mixed-up mother in Spiegel's case are depressing enough. The "backdoor"' world of the mental institution, as Goffman pictures it, is a nightmarish thing. For sheer horror, however, it would be hard to find anything more spine-chilling to read than Lifton's description of the techniques that Chinese Communists have perfected for destroying an established identity and replacing it with a different one.

And this, strangely enough, is all by way of saying that this report of the 3rd Macy conference on group processes is a thoroughly constructive, thoroughly scientific and thoroughly readable book. If the techniques of persuasion are sometimes used badly, it is still reassuring to know that interpersonal influence is a process that can just as well be studied as an instrumentality for the peaceful resolution of differences. Even now the behavioral sciences are in a position, as this conference shows, to provide some basis for the reorientation of leadership in certain strategic areas of our domestic and foreign policy. There *are* new and promising approaches to the broad problem of intercultural and international understanding. What can we lose by giving some of them a chance?

And, finally, in lighter vein: It was said, at the beginning of this review, that this is not a book about "group dynamics." Actually, there is one group very centrally involved in the experience reported—the conference group itself. There is a lot to be learned about persuasion in a scientific discussion on this level if one re-reads the book with attention focused on who said what, and when.—MURIEL W. BROWN, Social Security Administration, Washington, D. C.

HOME CONDITIONS: A SOCIO-MEDICAL STUDY OF 1,066 HOSPITALIZED PATIENTS WITH SKIN AND VENEREAL DISEASES

By Esbern Lomholt

Copenhagen, Rosenkilde and Bagger, 1958. 100 pp.

This paperback monograph presents statistical data and discussion of various socioeconomic factors in the environment of 1,066 patients who were attended on the service

of the Department of Skin and Venereal Diseases of Marselisborg Hospital, University of Aarhus, Denmark during the years from 1950 through 1953. Factors studied include age, sex, marital status, occupation, family income, mobility, overcrowding, alcoholism, family disorganization and broken homes.

Data obtained from medical and social histories were coded and placed on punch cards. Analysis reveals only two significant relationships between skin conditions and socioeconomic variables: atopic dermatitis occurred significantly more often in children from broken homes and ulcers occurred more often in men and women from poor homes.

This study further points to the complexities of psychosomatic mechanisms and the fact that very few simple linear relationships between causal agents and illness can be demonstrated. The authors state, for instance, in regard to one variable, that "irrespective of broken or unbroken homes, there is a relationship between emotional traumata and nervous complaints of all types." —WARREN T. VAUGHAN, JR., M.D., Western Interstate Commission for Higher Education, Boulder.

CONCEPTS AND METHODS OF SOCIAL WORK

Edited by Walter A. Friedlander

New York, Prentice-Hall, 1958. 308 pp.

In some 300 pages this book attempts to delineate the processes and ideology of social work along classic lines: casework, group work and community organization. The publishers claim that the book is "the first to bring into focus the dynamics of all three basic methods of social work." To my knowledge, this is true. And what makes the book even more practical is that it has an enlightening chapter dealing with the usually overlooked or underplayed social work methods of administration and research.

Concepts and Methods is—and makes no pretense of being anything but—a whacking good textbook. The most complex ideas are held successfully to simple presentations; the case histories and their concurrently running analyses are particularly fine; the psychological and sociological working concepts are lucidly and uncomplicatedly presented. This does not mean that the book does not have its moments of profundity. It does. Undeniably, however, nuances, subtleties, fine interrelationships were consciously sacrificed for clarity and comprehension. It is a book the beginning graduate or undergraduate student can pore over profitably for hours. It has considerable merit as a refresher for the practitioner. As a lucid training tool, I believe it stands without peer.

But to the sophisticated reader or to the professional eye, *Concepts and Methods* possesses possibly much deeper implications. Here, unfettered by complex philosophies and unclouded by historical considerations, stands the thought and quality of social work. The nude, in this case, is singularly unattractive. She is pockmarked by vague theories and blemished by ill-defined methods; her form is a patchwork of paradoxes and contrasts—incomplete, half-formed, unfinished. That a vital organism is being represented there can be no doubt. But the faults, the failings—not the vitalism—keep coming through, for the technique concentrates almost exclusively on the unflattering minutiae. Highlighted, by implication, is the constant introspection, the limiting analysis, the strained logic, the prevalent sophism; lost is the vigor, the sweep, the drama that every practitioner

knows is an inherent (if sometimes implicit) part of social work's concepts and methods.

Let this be made clear: nowhere in this book—except in acknowledging possible gaps in knowledge—is the case consciously made against social work as a system of thought. But this absence, to the seasoned or skeptical eye, implies much more than any affirmation can. *Concepts and Methods* is remarkable as much for what it leaves unsaid as for the theses it avows.—JOSEPH L. TORRES, Missouri Association for Mental Health.

SELECTED WRITINGS OF JOHN HUGHLINGS JACKSON

Vol. 1: On Epilepsy and Epileptiform Convulsions

Vol. 2: Evolution and Dissolution of the Nervous System

Edited by James Taylor

New York, Basic Books, 1958. Vol. 1, 500 pp.; Vol. 2, 510 pp.

In 1931 James Taylor put all neurologists and psychiatrists in his debt by collecting for publication the most important writings of John Hughlings Jackson (1835–1911). Previously scattered in a multitude of journals difficult to find, they were collected in two volumes. The first contained all his papers on epilepsy, the second his more general writings on neurology and psychiatry. These two volumes have been out of print for some time, and the present publishers should be congratulated on reprinting them.

In reading of Jackson's work it is important to remember the flimsy neurological foundations he had to build on. In 1864, when he had already published 30 papers, few neurological diseases could be differentiated. Even anatomical localization of disease was seldom possible. Most of the physical signs we use in neurology were unknown. Jackson used to say he had been in practice many years before the knee jerk was recognized. Apart from peripheral nerve injuries and one-sided paralysis from strokes and head injuries known since the days of Hippocrates, neurological diagnosis was rarely possible at that time. Out of this chaos Jackson and that group of late 19th-century neurologists of whom he was the greatest, devised an orderly approach to neurological diagnosis and laid the foundations of modern scientific neurology.

In the first volume are his papers describing the meticulous observation of epileptic seizures which led to the classification of various types of focal epilepsy: the "dreamy state" or temporal lobe attack, as we should now call it, and the focal motor attacks which bear his name. The clinical basis of cerebral localization, which he established but never overemphasized in physiological terms of function, was soon confirmed by the electrical stimulation experiments of Fritz and Hitzig in Germany and Ferrier in England. The earliest successful neurosurgery based on theoretical localization followed.

Inevitably some of Jackson's papers in the second volume have less significance today than others. There is little to be learned from the papers on vertigo save the ignorance of his time on that subject, though it is a sobering thought that even in those days Jackson distrusted the idea of dyspepsia as a cause of vertigo, a belief persisting to this day in some textbooks. Conversely, his stimulating papers on dysphasia remind one how little knowledge of this subject has progressed since his time.

Writing of Hughlings Jackson in the history of the National Hospital, Queen's Square, London, of which Jackson was the fifth physician to be appointed, Sir Gordon

Holmes said: "We find in his writings not superficial statistical reviews of a large material but the close study of a relatively small material. Nor was the recording of newly observed phenomena an end in itself for Jackson. Behind them he ceaselessly sought for the natural laws which they exemplified; this is the true philosophic method."

Those who study these classics of medical writing will see the truth of this assessment, and will recapture the excitement of his discoveries.—LEONARD D. OSLER, M.D., Boston University School of Medicine.

CURRENT TRENDS IN THE DESCRIPTION AND ANALYSIS OF BEHAVIOR

Nine lectures under the auspices of the University of Pittsburgh, March 11–12, 1955 and March 8–9, 1956

By Robert Glaser and others

Pittsburgh, University of Pittsburgh Press, 1958. 242 pp.

Each of the authors contributed one chapter —a lecture he gave at the University of Pittsburgh under the auspices of the psychology department. The lectures differ greatly in subject matter, scope, methods and manner of presentation.

Glaser describes, in very abstract and formal terms, the application of sociometry to small groups such as an artillery gun team. Zubin offers a model not for theories but only for the classification of certain observations and test results in tabular form, turning the clock back to the 1890's, on the ground that "the accumulation of isolated facts in psychopathology is impeding rather than accelerating progress." D. B. Lindsley writes about his own experimental animal work in electroencephalography, presenting new knowledge about brain organization. Nowlis demonstrates how the effect of drugs can be measured through reactions to stories built around guilt and fear; he devotes much space to defining mood. Cofer deals with some problems in the transfer of learning from one situation to another. Guetzkow reviews, in general terms, the effect of a number of models on theory and methods in the field of interhuman relations. Carroll shows on the basis of his experiments how emotional clues or suggestions influence the use of verbs and sentence structure.

The last two chapters deal much more directly with psychopathological phenomena than do any of the preceding ones. Hamlin rightly emphasizes both the practical and theoretical significance of psychotherapy and the need to investigate it despite methodological difficulties. He points to some ways of overcoming the difficulties. He pleads against avoidance of significant problems because methods for their solution are still unknown. French briefly but succinctly reviews motives and their modifications under the influence of repression. These lectures omit those methods which are used far more frequently and effectively in the study of mental patients than most of the techniques described in this book. Only some current trends in behavior analysis are covered in this book.—ZYGMUNT A. PIOTROWSKI, PH.D., Jefferson Medical College of Philadelphia.

RELIGIOUS DIMENSIONS OF PERSONALITY

By Wayne E. Oates

New York, Association Press, 1957. 320 pp.

This is a book that seems primarily intended as a textbook for theological students. Most of it is a compilation of theo-

logical information related to personality, and of psychological and psychiatric information regarding personality. At intervals the author puts forward his own interpretations and opinions. The information is rather loosely hung together, with insufficient integration. The interpretations and opinions are often well done. One wishes there had been more of them in proportion to the information. The author says, for example, that "religion and personality both defy adequate definition because they share the emphasis on the vital unity and indivisible totality of man in relation to himself, his attendant created order and the Creator; that "this insistence upon the uniqueness of man as an individual necessarily points man's religious quest in the direction of the discovery and realization of his individuality."

He frequently quotes Buber and Tillich, thus showing his debt to both Jewish and modern Protestant theology. He believes that the scientific conception of maturity is "a secularization of the religious conception of perfection and eschatology." He credits modern psychology with the "rediscovery of the intuitive depths . . . of the 'powers of darkness' which have been obscured by easy rationalistic kinds of thinking."

Those of us who started out in fundamentalism and have grown through various levels of religion and irreligion will appreciate his list of the "stages of religious maturity." He begins with the "religion of desire"—for example, for fertility, then that of "verbal interplay" with its "preoccupation with oratory and rhetoric," followed by the "religion of definition and exclusion," resulting in the "development of hierarchy." This stage leads to a "religion of rules" based on consolidation and conservation—soon resulting in rebellion and, may we devoutly hope, finally in the "religion of pure love."

Dr. Oates is unquestionably liberal in his outlook, in theological, psychological and racial matters alike. Since he is professor at Southern Baptist Theological Seminary this liberality is most refreshing. Despite the fact that some of his writings are rather turgid, both the theological and the psychological student can learn from his book a good deal of information about each other's views. With the help of his useful summaries and personal syntheses, each should broaden his own outlook and deepen his own thinking.—ROBERT A. CLARK, M.D., Friends Hospital, Philadelphia.

SYSTEMATIC SOCIOLOGY: AN INTRODUCTION TO THE STUDY OF SOCIETY

By Karl Mannheim; edited by J. S. Erös and W. A. C. Stewart

New York, Philosophical Library, 1958. 169 pp.

This depiction of Mannheim's view of sociology is based on the manuscript of lectures given in London in 1934–35 and later years. The editors, two of his former research students, have reorganized the argument, rephrased the text and omitted a number of the lectures on concrete issues of social structure in order to restore Mannheim's original plan for a systematic sociology.

There are four parts to the book. Part 1, on man's psychic equipment, contains thumbnail sketches of behaviorist and psychonanalytic concepts, W. I. Thomas's "four wishes," the process of socialization, the nature of daydreaming, the effect of private property ownership on personality, and other topics. Part 2 deals with such matters as social contact and social distance, isolation, individualization, and competition and monopoly. Part 3, on social integration, has chapters on the sociology of groups and

"the class problem." Part 4, on social stability and social change, treats social control and authority, customs, law and other sources of stability, and contains a presentation and critique of Mark's theory of social change. There is an incomplete but serviceable index and a bibliography of titles, almost all from the 1920's and 30's, selected by the editors as most relevant to Mannheim's argument.

The positive sides of the book are the brevity with which an impressive array of the central ideas of sociology and psychology are presented, the vigorous promotion of the view that the two disciplines are indispensable to each other, and the glimpses offered of the healthy synthesis in Mannheim of clear thinking and involvement in the task of seeking solutions to the social problems of our time.

The weakness of the book, a substantial one, is that it serves no live purpose. As a presentation of systematic sociology it is both dated and too advanced for the beginner. For the advanced student it is deadened with the exposition of elementary concepts. It will be most useful to those interested in the nature and development of Mannheim's own views. Unfortunately, they will be handicapped by the fact that there are no footnotes, so it is not always easy to separate Mannheim's original thoughts from ideas which come from others.—KENT GEIGER, Harvard University.

PSYCHOANALYTIC STUDY OF THE CHILD, 1957

Edited by Ruth S. Eissler and others

New York, International Universities Press, 1957. Vol. 12. 417 pp.

The twelfth volume of *The Psychoanalytic Study of the Child* continues the tradition of dividing the contributions in the following sections: psychoanalytic theory, aspects of development, clinical contributions and applied psychoanalysis.

It is impossible to review, within the limited space, even the most outstanding contributions collected here. The beginning paper is one by Charles Brenner on the concept of repression. This is an excellent historical review of the changes Freud made in his psychoanalytic theories, which are discussed in connection with the topic. It is very useful for teaching purposes and it signals the beginning of many papers which will reinvestigate the individual defense mechanisms. We have in this volume, in addition, Jeanne Lampl-DeGroot's thoughts on defense and development, and Seymour L. Lustman's on psychic energy and mechanisms of defense.

Those who are interested in clinical aspects will find here a detailed discussion on the work done at Yale as part of a longitudinal study of children. This program was directed by Ernst Kris. The paper presented is by Marianne Kris, who continues his work. This is a very stimulating paper with many important references to development focused on an investigation into the use of prediction. The methodology is outlined and case histories presented. Kris feels that "this procedure is one of safeguards against the attempt to resort to oversimplified theories of personality development." This study highlights the interest in psychoanalytic research in studying infancy and early development not only from the viewpoint of the pathology but of general psychological laws. These volumes have dedicated a good deal of their space to the contribution of psychoanalysis to development and to psychoanalytic psychology.

There are a number of papers on adolescence: Nathan N. Root discusses a neurosis in adolescence; Elisabeth R. Geleerd, some aspects of psychoanalytic technique in ado-

lescents; Peter Blos, preoedipal factors in the etiology of female delinquency, and Margarete Rubin, delinquency as a defense against loss of objects and reality.

Some of these papers, as the title indicates, deal with individual cases; others attempt to make generalizations about this stage of development or about the generally applicable modifications in therapy.

Bela Mittelman continues to study motility, which he started many years ago. In this paper he investigates motility in therapy, particularly restriction of freedom of motility and awkward motility and its psychological meaning.

These are just some examples of the papers presented. The editors of this book obviously want to show the full range of psychoanalytic study of the child. It brings together theory and clinical findings, problems of techniques and investigation into applied fields. For all those interested in psychoanalysis, this volume too must be on your reading list.—PETER B. NEUBAUER, M.D., New York City.

THE BRAIN AND HUMAN BEHAVIOR

Proceedings of the Association for Research in Nervous and Mental Disease, in New York, December 7–8, 1956

Edited by Harry C. Solomon and others

Baltimore, Williams & Wilkins Co., 1956. 564 pp.

The subject of this volume should be of intense interest to both clinical neurologists and psychiatrists and most of those basic scientists working in the laboratories and clinics of our institutions, such as psychologists, biochemists and neurophysiologists. In the introduction by the senior editor, Harry C. Solomon, the subject is defined as a challenging and intriguing one.

It was stated that philosophical and psychodynamic aspects were purposely omitted. This reviewer considers that the omission of a mature, thoroughly experienced philosopher who could provide the necessary background to the dichotomy of concepts between so-called brain and mind was unfortunate. Even if such an authority were only on the commission his comments in the discussion would have been invaluable. Indeed, the first paper by the late Karl S. Lashley, perhaps the most stimulating paper in the whole volume, tries to cover this problem of the philosophical background of these relationships. Such aspects of behavior as the will, memory, experience and insight, were touched on by Lashley in an interesting and scientific manner.

Although the text suggests that the papers will be limited to human behavior, one of the longest papers therein is largely devoted to the interpretation of motor behavior in monkeys who had lost, through surgical means, various areas of their cerebral cortex. This paper is an exceedingly valuable part of the book, however, and Denny-Brown and Chambers are to be congratulated on the completeness of this study.

The long psychological investigations by Lacey concerning autonomic activity are difficult to comprehend in relation to the total subject. An equally long paper by Wolff and associates covering much of the same material in different neurologic states in relationship to stress is much better presented.

There are a number of papers, notably one by Penfield and another by his psychologist, Milner, showing the deficits and alterations produced by removal of cortex in humans. Interesting papers on the electrical responses from deep areas of the brain in various neurologic states, as well as a number of carefully documented contributions on the effects of various drugs on hu-

man behavior, furnish difficult but very worthwhile reading.

Inasmuch as the volume was not limited entirely to human behavior, it is too bad that an authority like Professor Lorenz of Germany could not have been included in the group to add his tremendous knowledge of abnormal and normal behavior of a variety of animals under different environmental conditions.

This volume has surely pointed out the little we know about the higher function of the human brain.—ROBERT S. SCHWAB, M.D., Massachusetts General Hospital.

ONE MARRIAGE—TWO FAITHS

By James H. S. Bossard and
Eleanor Stoker Boll

New York, Ronald Press, 1958. 180 pp.

It was indeed a pleasure to read this book since it presents not only the scientific data of a sociological study, based on years of experience, but the application of human understanding and feeling to these observations. The style of the presentation lends itself to easy reading by the average intelligent layman, and also makes for interesting reading by the professional worker in the field of marriage counseling.

In a topic which can be clouded with much biased opinion and controversy, it is a tribute to the authors that they maintain a neutral attitude acceptable to all religious faiths and yet proceed to analyze the problems of interfaith marriages in a forthright and logical manner.

The authors emphasize their opinion that faith and religion represent a certain culture or subculture with all its traditions and mores; that bringing together in marriage a man and a woman of different faiths always implies additional stresses and strains because of the problems involved in attempting to harmonize different cultures. These problems become more evident after the honeymoon phase is passed, and are manifested by disturbances in sexual relationships, the development of hostilities between the marital partners and difficulties in family and social relationships. All of these problems are further magnified by the appearance of children in the family, and by everyday economic problems.

The presentation of illustrative case material and the official views of the major religious denominations is to be commended.

One drawback of the book is the lack of emphasis placed upon the role of unconscious forces and conflict in marriage problems, thus limiting its value for the more serious or sophisticated student working in the field. However, it should be on a required list of reading for persons of different faiths planning marriage to each other.—BERNARD M. PACELLA, M.D., New York City.

PSYCHIATRY FOR NURSES

By Louis J. Karnosh and
Dorothy Mereness

St. Louis, C. V. Mosby Company, 1958. 5th ed. 406 pp.

The fifth edition of Psychiatry for Nurses continues its role in nursing education that the four previous editions established.

It is an attractive volume printed on glossy paper. The subject matter is presented in 36 chapters with an index and a glossary.

The introductory chapter defines psychiatric nursing, and the nurse's need to understand herself and her role in psychotherapy is explained.

Chapters 2 through 4 review the development of man's understanding of mental

illness, and the present-day concept of the significance of heredity in such diseases is briefly outlined.

Chapters 5 through 9 define the structure of personality and the correlation body build with mental characteristics according to recent formulations. An abbreviated classification of mental diseases with nomenclature adopted by the American Psychiatric Association in 1950 provides authentic data.

Chapters 10 through 26 outline psychiatric disorders according to the diagnoses. Patient behavior is depicted and the nursing objectives in various manifestations of disturbance are included.

Case studies of individual patients are used to depict some significant symptom. Functional, organic, infectious and traumatic illnesses with their characteristic manifestations are described. Mention is made of epilepsy, mental retardation and personality disorders. The nurse may not meet these in a hospital for mental diseases but she may encounter them in general hospital situations or elsewhere and she should be prepared to interpret the behavior deviations observed.

Psychosomatic manifestations of illness may also occur in patients in general hospitals. The concepts underlying therapy employed is explained so the nurse may understand the purpose.

This fifth edition brings up to date the modern use of old drugs and new synthetic compounds employed in psychiatry. Psychosurgery and the need of retraining patients is particularized appropriately.

The reading lists following the various chapters are mostly taken from material published since 1950. Some exceptions are important background classics, currently used.

The diagrams used to illustrate physiological references are clear and helpful. The photographs of patients, illustrating behavior mannerisms, have been carried over from previous editions. Some of these are unnecessarily unsightly and could be advantageously omitted.

The text is intended to be used by student nurses and should be helpful as an adjunct to lectures and supervised practice.—MARY E. CORCORAN, Riverside, R. I.

EDUCATION OF THE CLINICAL SPECIALIST IN PSYCHIATRIC NURSING

Report of a national working conference at Williamsburg, Va., November 26–30, 1956

New York, National League for Nursing, 1958. 80 pp.

This book will be surprising and quite enlightening to those people who have felt that the principal trend in nursing today is away from clinical services and toward administrative and educational duties. It describes the role of the clinical specialist (perhaps "expert practitioner" would be a better term); discusses some of the ways in which the nurse participates in or carries out therapy; outlines the educational program which might prepare a nurse for such work; and speculates on the future of this newborn profession.

The events in the last quarter century, beginning with insulin and including World War II and the tranquilizers, brought about an almost explosive expansion of psychiatric practice. This subjected nurses to many demands for which they were inadequately prepared. About ten years ago the National League for Nursing obtained funds from the National Institute of Mental Health with which to explore ways by which education in psychiatric nursing could be improved. The earlier conferences were mainly concerned with administration, supervision, consultation, research and teach-

ing. The one reported in this book was intentionally limited to the nurse directly engaged in patient care.

While this book reiterates the traditional concept that nurses complement doctors and do not propose to replace them, it does see the nurse as being in the key position to influence the total living experience of the patient. She is expected to maintain a therapeutic environment and to influence the patient's behavior by her own. To do this, the nurse must be mature, well integrated, skilled in communication, and knowledgeable in the dynamics of behavior. This, in the opinion of the conference, calls for education at the master's degree level.

For the future, the conference concluded that the highly skilled psychiatric nurse who does not administer or do formal teaching will find difficulty in many institutions which are functioning along outmoded lines. She will also run into the policy (so thoroughly fixed in civil service) of rewarding administrators rather than performers, but she will in time make a place for herself.

The conferees included psychiatrists, psychologists, social scientists and nurse administrators as well as nurse educators. They were well aware that now and in the near future very few nurses with master's degrees will be doing bedside nursing. However, as a blueprint for what ought to be and as a guide for future planning this book will be referred to and quoted as a most significant document.—GRANVILLE L. JONES, M.D., Little Rock.

Notes and Comments

MENTAL HEALTH APPROPRIATION

Congress has appropriated $68,090,000 for the National Institute of Mental Health in 1960—$15,706,000 more than the President requested. It was, however, $6,000,000 less than the amount recommended by the National Association for Mental Health.

Paul Johnson, NAMH legislative committeeman, when he testified before subcommittees of the House and Senate last spring, asked $74,000,000 for NIMH—the increase to go for more training, community mental health services, professional and technical assistance, research projects, grants and fellowships.

Of the sum voted by Congress, $23,482,000 will go for research grants, including $3,800,000 for the mental health projects grants program (Title V) and $6,500,000 for the psychopharmacology program. This gives the Institute $6,553,000 more than was available last year for grant-supported investigations into the cause and cure of mental diseases.

In addition, $7,572,000 has been appropriated for research to be carried on in NIMH laboratories—$896,000 more than was allocated for the same purpose in 1959—and the sum for research fellowships—$1,996,000—represents an increase of $851,000 over the previous year's allowance.

Programs for training mental health personnel will receive the largest boost—$7,993,000 more than the 1959 sum, or a total of $26,206,000. Included in this total is $2,300,000 for general practitioners who wish to take postgraduate psychiatric training or psychiatric residency training.

NIMH was also given $5,000,000 for grants to the states, to help them in developing community mental health services; and $1,938,000 for professional and technical assistance to the states.

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The House appropriations committee report regarding this bill gave reasons for the increased appropriation:

"Recent figures presented to the Committee indicate that mental illness costs this country a minimum of $3 billion a year.

"Despite the staggering economic losses, the Committee received heartening evidence of remarkable progress against mental illness. . . . At the end of 1958 there were 52,000 fewer mental patients in all mental institutions than might have been expected on the basis of the rising curve from 1945 to 1955.

"Just the annual money savings resulting from this reduction amount to much more than this entire appropriation if calculated on the most conservative basis. It costs an average of $1,500 a year to provide little more than custodial care for each patient in a mental hospital and in institutions where good care and service is given the costs are much higher. Restored to a useful life this same person is earning his own living and paying taxes.

"Medical research that can increase our ability to prevent chronic mental illness is the only way of eventually cutting down on the nation's multi-billion dollar annual bill for care of the mentally ill."

The committee report also summarized recent research developments, including the use of new drugs and studies of the psychological aspects of mental illness. It noted that critical shortages of psychiatric personnel have impeded the successful treatment and recovery of the mentally ill —thus explaining the unusually large increase devoted to training programs.

Begun in 1959, the program for giving psychiatric training to general practitioners, the committee reported, has been "received with unprecedented enthusiasm by the medical profession. . . . Since the family physician is dispensing the greatest quantity of the new drugs, it is absolutely vital that he receive the psychiatric education he so avidly seeks. It will be expected that this program be expanded in 1960."

A separate section of the report, on juvenile delinquency, recommended research into "the psychological, emotional and environmental factors leading to deviant behavior in youth. From such knowledge can come means for preventing juvenile delinquency." It was suggested that the federal Children's Bureau and the NIMH should collaborate in such studies. "Accordingly, the Committee calls upon the National Institute of Mental Health to use such portions of the increased 1960 funds as may be necessary to undertake a most careful and thoughtful study of what can and should be done . . . in the field of juvenile delinquency." The committee also asked for a report from NIMH on its proposals for future action.

JUVENILE DELINQUENCY

Answering the directive of the House committee (see the item immediately above), the National Institute of Mental Health reported on its present juvenile delinquency program. The report stated:

"The Institute currently has a large-scale program of intramural research relating to children, and is supporting almost 200 extra-mural research projects concerned with children. . . . The majority of these projects are in the areas of mental retardation, delinquency, and other forms of deviant behavior in children, but the largest single category of projects is in the area of child development. . . .

"Specifically in the area of juvenile delinquency, the NIMH conducts a program of research, training, and consultation in the mental health aspects of delinquency."

Among the extra-mural research projects on delinquency which it is supporting are three described in detail in the report:

1) At the University of Michigan, "a community study focused on the psychological and social factors involved. It includes a study of middle class as well as lower class delinquents among both white and Negro youth, and is to culminate in an experimental delinquency prevention and treatment program."

2) At the South Shore Courts Clinic in Quincy, Mass., "investigators are attempting to classify into recommended treatment categories a sample of all delinquents coming to the juvenile court. This effort is based upon the evidence that disposition or treatment of delinquents is determined for the most part throughout this country by persons untrained in mental health or human behavior disciplines. It is hoped that findings from this project will permit treatment classification procedures which can be applied by at least some of such untrained or partially trained persons. Tentative findings from the pilot phase of this project indicate that at least half of all delinquents coming to the court merit intensive mental health or social work treatment."

3) At New York University, a project based on "the conviction of many experienced delinquency specialists that the provision of adequate treatment and preventive services in a high-delinquency area will now reduce the problem within tolerable limits . . . Dr. Chein of New York University has completed several years of valuable research on the psychosocial correlates of juvenile drug addiction and delinquency, and is convinced that such a

large-scale service project would be effective. He has designed such a project and the current grant is financing his exploration of the feasibility of this project or a similar one in New York City."

PSYCHIATRIC TRAINING FOR PHYSICIANS

One example of how NIMH is using its increased funds is the three-year grant of $68,364 awarded to the Western Interstate Commission for Higher Education to conduct a regional program of post-graduate psychiatric education for western physicians. The aim is to augment the ability of local physicians in the early detection and control of mental illness and improve their skills in the rehabilitation of ex-mental patients.

Dr. Warren T. Vaughan, Jr., WICHE mental health project director, said regarding the award: "In the face of the critical shortages of psychiatrists, it is obvious that most psychiatric conditions will have to be handled by the practising physician in the patient's own community. Many parts of the West are without psychiatric services. As a result, the level of psychiatric service available to the people in these areas will be determined by the psychiatric knowledge and understanding of the local physicians. We see this new WICHE program as a demonstration that greater use can be made of existing resources to ease, in part, the shortage of psychiatric manpower."

The program has been designed as a seminar meeting once a week for 10 weeks; students will be pediatricians, surgeons, internists and general practitioners, discussing typical psychiatric problems encountered in medical practice. Each seminar will be led by two qualified psychiatrists who will also be available for direct consultation by the participating physicians.

These study groups are being set up in four cities each year (12 western cities will be included in the three-year program) by the faculty of the Langley Porter Neuropsychiatric Institute, San Francisco, in cooperation with the WICHE mental health council. For the first year, Lebanon, Ore., Laramie, Wyo., Phoenix, Ariz., and Billings, Mont. will be the sites of the weekly seminars.

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Another phase of the NIMH program to encourage this trend—post-graduate psychiatric training of physicians—is the American Psychiatric Association's general practitioner education program, which NIMH is supporting with a grant.

William F. Sheeley, M.D., formerly of Minneapolis, was appointed to head this program at the APA headquarters in Washington, D. C. He and his associates are now developing the content and form in which such training can be brought to family physicians in their own communities.

Dr. Sheeley, 42, was in the Army and Air Force from 1942–1955, serving as a flight surgeon, an intelligence officer, and in aero-medical research. He did graduate work in psychiatry at the University of Minnesota and was certified by the American Board of Psychiatry and Neurology in 1955. Thereafter he served for two years as acting superintendent of Hastings State Hospital in Minnesota, and was chief of psychiatry at Minneapolis General Hospital, also assistant professor of psychiatry at the University of Minnesota.

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A southern conference—indeed, the first regional conference on the training of physicians in basic psychiatric principles—was held in Atlanta, October 8 and 9, 1959, with delegates from 16 southern states.

Sponsored by the Southern Regional Education Board, the conference presented speakers who are key men in the fields of

medicine and psychiatry. They discussed the incidence of emotional and psychological disturbances in a physician's practice; the need for general practitioners to understand these disturbances; and successful programs now used in teaching physicians these basic psychiatric principles.

Dr. John G. Walsh, president-elect of the American Academy of General Practice, opened the meeting with a discussion of the practitioner's responsibility to his patients in the matter of emotional and psychiatric symptoms related to an illness.

"Patients want the old-fashioned kind of doctor who treats the whole person," said Dr. Walsh. "Modern specialization has cost us the personal touch between doctor and patient."

He said a large percentage of any doctor's patients come to him with disturbances which need some psychiatric consideration, but which can be handled outside of a psychiatrist's office.

Dr. Robert H. Felix, president-elect of the American Psychiatric Association and director of the National Institute of Mental Health, cited a number of specific illnesses which involved psychological or emotional problems. Among these he included obesity, diabetes, heart diseases, and ulcers.

The secret of medical practice is in caring about a patient while you care for him, said Dr. Leo H. Bartemeier, medical director of the Seton Institute and chairman of the Council on Mental Health, American Medical Association.

He suggested that psychiatric training begin with medical students at a time when emphasis on the scientific method tends to overshadow the young doctor's relation to his patient.

Dr. Raymond Feldman, director of the training and standards branch of the National Institute of Mental Health, discussed training funds available from the NIMH for post-graduate courses and to help schools improve their teaching of psychiatry.

One of the final discussions was a sampling of successful post-graduate programs used throughout the country, ranging from individual discussion groups to formal, region-wide programs for physicians in the southern states by Dr. William Rottersman, Atlanta psychiatrist. Dr. William P. Hurder of the Southern Regional Education Board offered the SREB as a secretariat-sounding board-evaluating agency in implementing any regional program.

NEW DIRECTOR OF NAMH

The new executive director of the National Association for Mental Health, Lawrence J. Linck, took office on September 1. Word of his appointment came too late for inclusion in the October issue of *Mental Hygiene.*

Mr. Linck has had a long and distinguished career in the health and welfare field. He was executive director of the National Society for Crippled Children and Adults from 1945 to 1956. From 1940 to 1945 he served as executive director of the Illinois Commission for Handicapped Children, and from 1941 to 1945 as director of the University of Illinois Division of Services for Crippled Children.

From 1956 until he accepted his new post, Mr. Linck was a professional management counselor with offices in Chicago, serving corporations, associations and foundations in the U. S. and Brazil.

He has been a special consultant to the U. S. Public Health Service, and consultant to the Office of Vocational Rehabilitation in the U. S. Department of Health, Education and Welfare; member of the Committee for the Handicapped, the People to People Program; and editor of *The Crippled Child* magazine. He has also served

as a member of the National Advisory Committee on Maternal and Child Health of the U. S. Children's Bureau and the National Commission on Children and Youth.

The new mental health executive previously held lectureships in the College of Medicine of the University of Illinois, the Institute of Social Administration at Loyola University and University College of Northwestern University.

He is presently chairman of the committee for the 8th World Congress of the International Society for the Welfare of Cripples, to be held in New York in 1960. He is also treasurer of the International Society for the Welfare of Cripples and trustee-at-large of the National Society for Crippled Children and Adults.

In announcing the appointment, Judge Luther Alverson, president of the NAMH, said, "We are very fortunate to have Mr. Linck as our executive director. His long years of service and experience in the health and welfare field will bear directly on our work and will help our organization develop new momentum in its fight against the nation's number one health problem —mental illness. His leadership in the administrative field should prove invaluable, too, in helping our 800 state and local affiliates to increase their service to the people in their communities, and in bringing many hundreds of new affiliates into being throughout the country."

INTERSTATE COMPACT

Twenty-two states have now ratified the Interstate Compact on Mental Health, which provides that hospital care and treatment for the mentally ill shall be given to each person who needs it even though he may legally be resident in another state. It also permits the transfer of a mental patient to an institution in another state when such transfer would be in the patient's best interest; and provides interstate cooperative machinery for aftercare or supervision of patients on convalescent or conditional release.

At the last meeting of its legislature, Ohio became the 22nd state on the list. Others which had previously ratified the Compact are: Alaska, Arkansas, Connecticut, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Vermont and West Virginia.

MORE FUNDS FOR MENTAL HEALTH

A new peak of $64.8 million in federal, state, and local funds was budgeted by the states for community mental health services in 1959, according to the National Institute of Mental Health. The total represented a 20% increase ($10.8 million) over the funds devoted to this purpose during the previous year. Most of the money was spent for increasing staff, research and training; about $9 million was used for clinical and local mental health services.

AGING

Preparations for the White House Conference on Aging, to be held in January 1961 at Washington, D. C., are well underway. Secretary Arthur S. Flemming, of the Department of Health, Education and Welfare, has named seven regional representatives, and two more will be appointed later. They are to assist states and communities in their regions to prepare for the Conference. The White House Conference staff and the Department's special staff on aging, both directed by William C. Fitch, are now preparing background papers, pamphlets and booklets for use at community, state and regional meetings

which will be held prior to the Washington conference.

Secretary Flemming has also named 130 outstanding citizens to serve on the national advisory committee for the conference. The committee chairman is former Congressman Robert W. Kean, of New Jersey.

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Aging was also listed as one of the areas of major interest for World Mental Health Year by the World Federation for Mental Health at its annual meeting in September.

PUBLIC HEALTH OFFICERS

Consolidating community public-agency services concerned with physical and mental health was advocated by the long range planning subcommittee of the Association of State and Territorial Health Officers, which met in Washington, D. C., October 15–16. A draft report submitted to the Association outlined the recommendation:

"While there may be at state level some dispersion of official responsibility for medical and health programs, this Association holds strongly that at the local level there should be a consolidation of all community programs concerned with health, physical and mental. . . . Local health departments should be so strengthened that the local services for physical and mental health needed by various state agencies could be provided through a consolidated local program."

The committee also recommended that responsibility for physical and mental health, aside from institutional care, be unified in public health programs of the future:

The Association urges a re-evaluation of the inter-relationship of health programs for the protection and promotion of physical and mental health. It recognizes that activities in mental health in their development frequently were associated with programs for the hospital and clinic care of the mentally ill. The extension of public mental health from this source has resulted in a division of the health program. At first this seemed not unnatural since when this new public health program was initiated there was so little in common in the training of those concerned with mental illness as compared with those working in the general public health program. It is the view of the Association that the hospital care of the mentally ill advantageously can be handled separately, but that otherwise problems in physical and mental health in the individual and in the community are inseparably intertwined. It is strongly recommended that in the public health program of the future the non-institutional responsibility for physical and mental health be unified. This will demand an extension in the training of public health workers (particularly of health officers and public health nurses) in the behavioral and social sciences. Also to the already multi-disciplinary staff of health departments, there will need to be added those with specialized training in the social sciences who will need also sound training in general public health. A firm acceptance of the ultimate goal of the unification of community programs in physical and mental health, but a readiness to move toward it through a gradual transition, is recommended.

Reactions of Association members to these recommendations varied from approval to strong criticism. Here are some of the comments:

"A shying away from responsibility for institutional care of the mentally ill is noted. It would seem that the institutional program and the community program are inseparably intertwined. In view of this health departments might reconsider their future potential roles in the institutional

care of the mentally ill." "This (separation of hospital care) fragments the patient's care and makes continuity more difficult."

"We support this merger because in a small state such as ours we do not need a separate Department of Mental Health. All individuals and groups who support mental health in the community have argued for integration and consolidation of the mental health program. In fact, many of them have recommended that there be a separate Department of Mental Health integrating the institutional and community program, taking the latter program away from the Department of Health."

YOUTH

Juvenile delinquency tops a list of 40 major "areas of concern" reported by 45 of the state committees preparing for the Golden Anniversary White House Conference on Children and Youth. This conference, with 7,000 participants will be held in Washington, D. C., March 27 to April 2, this year.

In every state, also the District of Columbia, Puerto Rico, Guam, American Samoa and the Virgin Islands, a committee appointed by the governor is preparing a report on existing services and unmet needs affecting young people; these reports, now being analyzed at Conference headquarters, will be published for use at the Conference.

A questionnaire answered by these state committees has shown that 45 states are most concerned with prevention and treatment of juvenile delinquency. Next on the list is the problem of emotionally disturbed children, listed by 32 states. Other major concerns in the order of their importance, are: retarded children (treatment and training); religious and spiritual life of children; establishing values and ideals in children.

Called together by President Eisenhower "to see that we prepare today's children well for life in tomorrow's world," this will be the sixth decennial White House Conference on Children and Youth held since 1909. President Theodore Roosevelt called the first one; and its continuing activity has influenced such forward developments as federal and state child labor laws and establishment of the Children's Bureau.

"The Conference is more than a five day meeting in Washington," said Ephraim R. Gomberg, executive director of the Conference. "It is an 11-year process of study and action—one which has already commenced in every state and will continue until the next Conference in 1970."

MENTAL RETARDATION

Congress has appropriated $1,000,000 for the expansion of education for mentally retarded children. The Commissioner of Education will use this sum to make grants to public or nonprofit institutions of higher learning for the training of professional personnel who in turn will train teachers of mentally retarded children.

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Today 44 states have programs for the retarded, according to the National Institute of Mental Health, whereas five years ago only four states had such programs. Growing interest in providing services for the retarded has led 20 states to set up legislative commissions to study their needs.

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A possible relationship between virus illnesses in infants and mental retardation later in their lives has been indicated by research at the North Little Rock, Ark., Veterans Administration hospital and the University of Arkansas Medical Center.

Researchers Dr. Carl E. Duffy, professor

and chairman of microbiology at the medical center; Dr. Oddist D. Murphree, chief of the VA hospital's research division; and Dr. Thomas T. Frost, the division's chief pathologist, working with laboratory animals, have found that a virus infection acquired early in life can have an adverse effect on the development of the nervous system—and thus affect an individual's learning ability. They believe that virus infections can be blamed for some of the cases of mental slowness in which heredity previously was considered the controlling factor.

The older the animal, according to these scientists, the less effect virus infections had in causing retardation. Animals eight days old when inoculated with a virus inducing illness were far slower mentally than those inoculated when they were 14 days or older.

This animal research lays the foundation for clinical research to be done later on humans.

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"Education of the Severely Retarded Child" is a bibliography of more than 300 titles published by the Office of Education Only a few of the titles listed were published before 1950. Copies may be obtained from the Government Printing Office for 15¢ each.

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"Success in Employment of Educationally Subnormal Children," an article by J. E. Collins, B.A., Ph.D., Dip. Ed. Psych., in *The Medical Officer* (London), October 2, 1959 issue, reports on a study of the children who left Pencalenick Residential School between 1952 and 1958. Dr. Collins reports that 57% were successful in employment in an area where unemployment figures are considerably higher than the national average.

"This investigation suggests," he writes, "that success in employment of educationally subnormal children may be linked with levels of intelligence, attainments at the time of leaving school and with home conditions."

DIRECTORY

The 1960 Directory of American Psychological Services is an enlarged and approved list prepared and distributed by the American Board of Psychological Services, Inc. (The earlier edition was reviewed in *Mental Hygiene*, April 1959.) The list comprises 176 individuals and services in the United States and four in Canada that have applied for listing and meet the qualifications of the American Board of Examiners in Professional Psychology. In addition to the standards for Diplomate status, the directory presents a geographical list of the Diplomates of the A.B.E.P.P., Glendale, Ohio. Price $1.50.

RIGHTS OF CHILDREN

A United Nations charter for the world's children was formally approved by the General Assembly's Social, Humanitarian and Cultural Committee on October 19, 1959. Among the principles enunciated by the Declaration of the Rights of the Child, these concern mental health:

"The child shall . . . be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. . .

"The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.

"The child, for the full and harmonious development of his personality, needs love

and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and in any case in an atmophere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. . . .

"He shall be given an education which will . . . enable him on a basis of equal opportunity to develop his abilities, his individual judgment and his sense of moral and social responsibility. . .

"He shall be brought up in a spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood and in full consciousness that his energy and talents should be devoted to the service of his fellow men."

WFMH NEWS

The 13th annual meeting of the World Federation for Mental Health will take place in Edinburgh, Scotland, August 7 to 12, of this year. Theme of the meeting will be "Action for Mental Health."

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Peru was one of the first countries to allocate funds for the promotion of national activities for World Mental Health Year, and is the first country of the world, according to WFMH, to give official recognition to the Year. A government statement, issued in Lima in June of last year, promised that "the Council for Mental Health will be responsible for the carrying out of inquiries on a national level in the field of mental health and the study of the sociological aspects of industrial development in relation to mental health; and that the result of this work shall be made known in the scientific meeting which shall be convened at an appropriate time as a contribution from this country to the activities of World Mental Health Year."

At a meeting of the U. S. Committee of the WFMH, Dr. John R. Rees, British psychiatrist who is director of the Federation, reported that mental and emotional disturbances are increasing in underprivileged countries as well as in the "overprivileged western nations." He said the increase in the poorer countries "probably is linked with rapid industrialization and change which disturbs existing cultural patterns."

William T. Beaty, II, assistant executive director of the New York State Association for Mental Health, was elected president of the Committee; Mrs. Grace E. O'Neill, general secretary; Mrs. Charles S. Ascher and Mrs. Jonathan Bingham, vice presidents. Honorary presidents Mrs. Clifford W. Beers, Dr. Earl D. Bond, Mrs. Henry Ittleson and Dr. Arthur H. Ruggles were re-elected. The other officers elected at this meeting are: Mrs. Jonathan Bingham, chairman of the governing board; Mrs. George A. Stern, chairman of the executive committee; Dr. Robert L. Sutherland, treasurer; and Dr. George S. Stevenson, assistant treasurer. Dr. Margaret Mead, Dr. Bertram H. Schaffner and Lewis Cullman were elected to the governing board.

NEW SCIENTIFIC COMMISSION

The Commission of Neurochemistry, of the World Federation of Neurology, met for the first time at the Institut Bunge in Antwerp, Belgium, September 29 and 30, 1959. Neurochemists from Germany, Sweden, England, Netherlands, Belgium, England, Canada, and the United States, twelve in all, were invited and constituted the original Commission. They named Dr. A. Lowenthal, of Antwerp, as secretary; and agreed to establish a permanent secretariat at the Institut Bunge. A symposium on neurochemistry will be held in Rome during the Congress of Neurology of 1961.

SURVEY OF MENTAL HEALTH RESEARCH

The Southern Regional Education Board has made a state-by-state survey of mental health research, including research in mental retardation. Results of the survey, transferred to IBM cards, provides information on current work in progress in the south, and how it is being carried out, also an all-over look at the south's resources and needs in such research. This data was presented to a meeting of educators, legislators and researchers in November, 1959, and is now available from SREB to all interested persons.

SREB AWARDS

A program to enable mental hospital and related personnel to observe and acquire training in new mental health programs conducted by other institutions in the country was set up by Southern Regional Education Board in 1958 with a grant from the National Institute of Mental Health. Since its inception, the Board has made awards to over 100 employees of mental hospitals and training schools in 11 southern states for visits to other institutions in 22 states and Canada.

COLLEGE STUDENTS HELP MENTAL PATIENTS

Washburn University students are helping to provide a new therapy at the Topeka, Kans., Veterans Administration hospital. They offer companionship to mental patients in the activities available at the hospital—bowling, swimming, riding bicycles, shop work, playing cards, and other games and sports.

Ten students are participating; each spends about two hours a week with the patient assigned.

"We chose college students because they are youthful, energetic and vigorous," said Dr. R. G. St. Pierre, hospital manager. "We selected patients who, we felt, could benefit from close companionship and taking part in activities with an interested person."

NEW PSYCHIATRY SCHOOL

The New York School of Psychiatry, a graduate school offering basic and advanced psychiatric education, has been opened by the New York State Department of Mental Hygiene for its medical personnel.

Offering a three-year training program, the school operates under a provisional charter granted by the Board of Regents of the University of the State of New York. It serves the staffs of Brooklyn, Creedmoor, Kings Park, Pilgrim and Central state hospitals and Willowbrook State School.

Similar graduate training is provided by the Department in cooperation with medical schools for other state hospitals. The program is intended to provide instruction for physicians planning a career in public psychiatric hospitals or mental health clinics; and to insure the specific training required for such positions. The program also serves as a means of recruiting psychiatric personnel for the institutions administered by the Department.

Eligibility depends on the following requirements: graduation from a medical school acceptable to the New York School of Psychiatry; completion of at least one year of internship at a hospital acceptable to the school; and appointment as a resident or staff member at one of the associated state mental institutions.

Instruction includes a basic curriculum in psychiatry, requiring two years, and advanced curriculums in specialized areas. The school is in the medical-surgical building of Manhattan State Hospital on Ward's Island, and includes an out-patient clinic. Students, closely supervised, will work with

hospital patients and in the outpatient clinic.

The Department also has local training programs in other state institutions. In addition, a 10-week postgraduate course for senior psychiatrists is now being offered at the Psychiatric Institute in New York City.

SUICIDE

A community center to treat suicidal persons has been set up at the Los Angeles General Hospital, with a grant of $377,000 from NIMH. This will be a five-year research project, staffed by psychiatrists, psychologists and social workers; its aim is to gain more scientific information on suicide. Community agencies are making referrals of would-be suicides to the center, and the center is using public and private treatment facilities to handle patients.

Edwin S. Shneidman, Ph.D., University of Southern California, and Norman L. Farberow, Ph.D., Veterans Administration, the principal investigators, who have done previous research on the subject, have collected data on all suicides or attempted suicides in the country during the last 10 years. According to NIMH, the center "is recognized as the scene of the most comprehensive research on suicide both here and abroad."

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A report on suicide, titled "Smashup" appeared in *Newsweek,* November 2 issue. The article gave statistics similar to those which were published, in the first article on the subject by Dr. Joseph Hirsh, in the October issue of *Mental Hygiene.* Part II of Dr. Hirsh's four-part series appears in this issue. The *Newsweek* article included information obtained from the Los Angeles suicide prevention center (see above).

HALF-WAY HOUSES

To help convalescing mental patients of the Gulfport, Miss., Veterans Administration hospital adjust to normal community life, the hospital has arranged for their stay in two "half-way houses" in a quiet residential section of the city. These are operated by private owners, carefully chosen by social workers.

The experiment was begun in the summer of 1958 and so far, the hospital reports, has succeeded in its purpose.

Veterans living in the houses—36 are accommodated—return to the hospital during the day, Mondays through Fridays, to continue in therapeutic activities. Otherwise, they are on their own. They pay their own expenses from compensation and pension checks. They are selected for the experiment when they are deemed capable of attending to personal needs and handling money—ready to assume some responsibility.

Community acceptance, the VA reports, has helped the program to succeed. Many neighbors have asked VA officials how they can assist the ex-patients. All are free to participate in community recreational activities, and they may leave the city on visits to their friends and relatives.

DRAMA FOR PARENTS AND TEACHERS

Parent-teacher relationships have been dramatized in a one-act play, "I'll See You After School," written by Dr. Loyd W. Rowland, director of the Louisiana Association for Mental Health.

The play is about four mothers, each with a typical problem, and their separate conferences with the teacher who has their four children in her class. Through the conference, the teacher and the parent of each child gain a better understanding of the child's behavior.

On the basis of numerous presentations before the public, Dr. Rowland's play has been adapted to suit general audiences. It has been published, as a small, paper-bound booklet, by the Louisiana association and is available for production for a minimal sum—$1 royalty for each presentation.

According to a note in the published text, the play was written "to emphasize the need to revive the waning art of communication between parent and teacher."

"Experience shows that discussion following the play will be quite lively. People see in the problems presented reflections of their very own." A discussion guide is included with the play.

"I'll See You After School" (at $1 for single copies, $5 for a 7-copy production kit) may be obtained from the Louisiana Association for Mental Health, 1528 Jackson Avenue, New Orleans 13, La.

PSYCHIATRIC AIDES CERTIFIED

A system of state certification for qualified psychiatric aides in California mental hospitals was established by law when Gov. Edmund Brown signed the bill titled SB 732 last summer.

The State Board of Licensed Vocational Nurse Examiners is now setting up standards and otherwise administering the new measure. The Board will begin issuing certificates after July 1 of this year. Certification is optional, but early applications are expected from a large majority of the nearly 10,000 psychiatric technicians employed by the Department of Mental Hygiene and graduated from its 300-hour, one year, in-service training program.

With the new law, California becomes the third state in this decade—along with Arkansas and Michigan—to provide some form of legal assurance of the competency of its better prepared psychiatric aides, as a distinctive quasi-professional group.

Many groups have worked to realize this goal of certification. Co-sponsored by the state Psychiatric Technicians' Society and the State Employees Association, the legislation was supported by the California Department of Mental Hygiene, the California Association for Mental Health, and all major state organizations concerned with nursing.

It also reflects the objectives of aide groups in other parts of the country. Since 1944 NAMH has pioneered in advocating the development of nationally recognized standards for psychiatric aides and measures that would assure the professional ability of such mental hospital personnel.

PSYCHIATRIC RESIDENTS

The total number of psychiatric residents in training increased by 30% between August 1956 and August 1958, according to Fact Sheet 11, the latest report of the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health.

This report also states that "the number of approved programs in which residents were enrolled increased from 215 to 245" over the same period. In 1956, there were 52 centers with no residents, despite the fact that the centers offered approved programs for psychiatric training. Two years later this number went down to 23 centers.

Residents in training were unevenly distributed geographically, according to the report, which shows that the New England and Mid-Atlantic states had almost twice as many residents per 100,000 population as did the rest of the country. Ten states had

no psychiatric residents in training and 22 states had none in training in their state hospitals.

Psychiatric residents with a foreign medical school degree increased 54%, or from 693 to 1,071, between 1956 and 1958, the report indicates. Residents with domestic degrees during this time increased by only 23%.

AWARD TO VOLUNTEER

Mrs. Jessie Hughes, of St. Louis, Mo., a volunteer at the St. Louis State Hospital, received the Lane Bryant Individual Award of $1,000 last November for volunteer service to the community. She is the first individual associated with a mental hospital to receive this award; in 1951 it was given to a group—the Milwaukee County Association for Retarded Children.

Mrs. Hughes organized a corps of lay volunteers to work with mental patients at the 3,300 bed hospital. In her speech of acceptance, she said, "Over one-third of our patients never have a visitor, never receive a letter, never get a gift. Quite often they have to learn from volunteers that friendliness exists in the world before they are accessible to therapy."

DR. STEVENSON CONTINUES AS EDITOR

Dr. George S. Stevenson, editor of MENTAL HYGIENE, retired as national and international consultant of the National Association for Mental Health on December 1. He is, however, continuing the editorship of this journal until a new editor is appointed.

Dr. Stevenson began his association with the National Committee for Mental Hygiene (predecessor of NAMH), as a field consultant in 1926; he became medical director of that organization in 1939. When the committee merged with the National Mental Health Foundation and the Psychiatric Foundation in 1950 to form NAMH, his position became that of advisor on the planning and organization of mental health services here and abroad.

He is presently psychiatric consultant to the U. S. Public Health Service and the Veterans Administration, treasurer of the World Federation for Mental Health, and associated with a number of other social service agencies and professional organizations.

CORRECTION

An error appeared in one of the references listed for the article, "Healthy personality and self-disclosure," by Sidney H. Jourard, Ph.D., published in the October issue of *Mental Hygiene*. The book was incorrectly listed as: "Jourard, S. H. *Healthy Personality: An Approach Through the Study of Healthy Personality*, New York, Harper and Brothers, 1958." The correct reference should be: *"Personal Adjustment: An Approach Through the Study of Healthy Personality*, New York, Macmillan, 1958."

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a coordinated citizens organization working toward the improved care and treatment of the mentally ill and handicapped, for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.